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ABSTRACT

In 1994, the federal Office of Rural Health Policy awarded 3-year outreach demonstration grants to 81 projects to provide direct primary and preventive health care services to rural residents in 42 states and 2 U.S. territories. The outreach grant program allows recipients to test innovative ideas against the persistent problems of rural health care, such as provider shortages, fragmented delivery systems, and geographic isolation. Recipients are required to form a consortium of three or more local institutions to work together toward project goals. Overall, the projects addressed a broad range of rural health care needs. Over half focused on the specific needs of mothers, infants, children, and adolescents. Rural minorities, including Hispanics, African Americans, and Native Americans, were the primary beneficiaries in 25 projects. Twenty-four addressed the needs of the elderly, and seven targeted migrant and seasonal farmworkers, offering bilingual, culturally specific information and services. Twenty-two projects focused their activities in rural schools, which are convenient and effective sites for rural service delivery. Almost every project provided some type of health promotion/education programming for the public. Over 25 percent provided continuing education opportunities to health professionals. Important project elements included volunteerism, use of telecommunications technologies, and provision of mobile services or client transportation. Short descriptions of the 81 projects summarize activities and include innovative features, obstacles encountered, reasons for success, and contact information. (Contains title and subject indexes.) (SV)

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The Outreach Sourcebook - Volume 4

Rural Health Demonstration Projects 1994 to 1997

Author: Teri Randall

Project Officer: Jake Culp

September 1998

Health Resources and Services Administration
5600 Fishers Lane, Room 9-05
Rockville, MD 20857
(301) 443-0835

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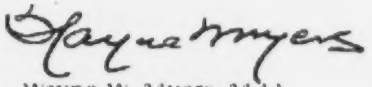
Since 1991, the Office of Rural Health Policy has awarded more than 350 Rural Health Outreach Demonstration Grants throughout the country. Averaging about $550,000 over three years, the grants are intended to encourage the development of innovative health care delivery systems in rural communities that lack essential health care services. The projects developed under these grants differ in their objectives and activities, yet they all involve a consortium of three or more organizations working together to improve health care in their communities.

This report summarizes the experiences of the group of grantees funded in September 1994. As a group, these grantees have been enormously successful in securing the continuation of project activities after the grant period. Thus, they have created lasting improvements to health care in their communities. Also of lasting benefit are the new working relationships forged through the consortia. As a result of these collaborations, the grantee communities have enjoyed stronger communication networks between providers, improved referral patterns, and enhanced continuity of care.

This report relates the individual stories of these outreach projects — their successes and failures, their greatest challenges, their solutions to these challenges, and their plans for the future. The information presented here is based on reports prepared by the grantees during May and June 1997 and consequently does not reflect the final few months of effort under their grants.

Emerging from these pages is a picture of the diversity of rural communities, the problems they face in assuring access to basic health care services, and the collaborative spirit that is rising to address these problems. We believe that rural community leaders, new program applicants, health policy makers, and others who read this report will find it a valuable source of innovative ideas on rural health care delivery.



Wayne W. Myers, M.D.
Director
Office of Rural Health Policy

In 1994, the Office of Rural Health Policy awarded outreach demonstration grants to 81 projects located in 42 states and two United States territories. (A map showing their locations follows this overview.) These projects have provided direct primary and preventive health care services to an estimated 800,000 rural residents during the three-year grant period. In addition, many thousands more have benefited from the enhanced knowledge and skills gained by their health care providers in continuing education opportunities. Most projects have succeeded in securing their financial viability after the grant, ensuring better access to health care in their communities for many years to come.

The outreach grant program has allowed recipients to test innovative ideas against the most persistent problems in rural health care. Provider shortages, fragmented delivery systems, cultural and language barriers, uninsured populations, and geographic isolation are just some of the challenges these projects have encountered. With the help of dedicated professionals, volunteers, and community support, these projects have fashioned creative solutions to provide vital services to their communities. Many have already witnessed measurable improvements in the health of the people they serve. A brief summary of the projects is presented here, followed by their individual stories.

Taken as a whole, these projects address a broad range of rural health care needs, including primary and preventive health care, emergency medical services (EMS), hospice care, dental care, substance abuse treatment, mental health counseling, and programs for those with developmental and learning disabilities. Social concerns that affect public health are also addressed, including family violence, teen pregnancy, teen delinquency, and the special needs of the elderly and their caregivers.

More than half of these projects focus specifically on the needs of mothers, infants, children, and adolescents. Rural minorities, including Hispanics, African Americans and Native Americans are the primary beneficiaries in 25 projects. Twenty-four address the specific needs of the elderly and caregivers of the elderly, and seven target services to migrant and seasonal farmworkers. Almost every project provides some kind of health promotion/education programming for the public.

Although most projects focus their efforts within a single county, some provide specialized services to larger areas. The ***Save Our Farm Youth*** project (Project 63) in South Dakota, for example, provides farm safety day camps to children in every county in the state. More than 14,000 children have already participated. The ***Call For Health*** project (Project 68) operated by the National Center for Farmworker Health in Austin, Texas, provides a bilingual, toll-free health information and referral resource for the nation's four million migrant and seasonal farmworkers and their families. And the Republic of Palau, a Freely Associated State in the southwest Pacific, has implemented the ***Palau Lead Poisoning Prevention Program*** for the entire island nation (Project 80).

The Office of Rural Health Policy awards these demonstration grants to a wide variety of organizations, including hospitals, local health departments and other government agencies, community health clinics, Native American tribal organizations, and universities. Recipients are

required to form a consortium of three or more local institutions that will work together to meet project goals. The purpose of this requirement is to foster cooperation in rural communities and the sharing of scarce resources. Consortium members can be health care providers, government agencies, educational institutions, or any other organization, public or private, profit or non-profit. More than five hundred rural organizations have participated in the consortia organized by these grantees.

The consortium arrangement has played a crucial role in the success of these projects. By combining their strengths and resources, consortia members have found that they can explore innovative ideas, solve problems, develop networks and referral patterns, and deliver comprehensive services more effectively than individual members acting alone. As the grant period progressed, many of these successful networks expanded to include more agencies, creating an even larger pool of expertise and resources. By the end of the grant period, a large number had proven so fruitful that members were planning to continue or even expand their collaborative efforts.

While some consortia had been working together long before applying to the outreach grant program, in a majority of projects, the relationships formed under the grant represent the first time these agencies have worked together on a formal basis. This brought up some challenges, particularly when members had strong philosophical differences. Wrote one project director, "Coalition members coming from different focuses, e.g. for profit, non-profit, religious, and governmental, need to listen to and understand other members' organizational philosophies." These diverse consortia can be successful, she continues, if members share a mutual vision and have well-defined roles.

Each project is encouraged to become self-sufficient by the end of the grant period, and this group of grantees has been particularly successful in meeting this goal. As of May 1997, 56 of the 81 projects (70%) had secured funding for the continuation of all grant-related services after their outreach grant expires. Of these 56, seven expect to be fully self-sufficient through reimbursement of services (Medicaid, Medicare, and private insurance) and/or service contracts. The other 49 plan to supplement their revenues with additional funds from local, state, and federal sources; fundraising; grants; and in-kind contributions from consortium members. Of the remaining 25 projects, 15 (18%) were waiting to hear from funding sources and were confident that some project activities would continue after the grant. Six planned to offer only limited services after the grant period. And only four of the 81 projects will discontinue all activities.

Probably the most frequently cited secret for success mentioned by project directors is the ability to remain flexible and responsive to the actual needs and available resources in the community. Many projects conduct focus groups during the initial phase of the grant. Others form ongoing advisory committees to ensure that project activities meet identified needs within their target populations. Projects that extend these efforts continue to reap the rewards of community support and participation.

One community that has totally embraced its outreach project is Livingston, Montana, home of the *Living Steps Wellness Center* (Project 41). More than 3,400 adults (more than one-fifth of the

county's 16,000 residents) have participated in the project's screening programs. In addition, the project's public health education classes have drawn more than 2,100 adult participants. And its new Fitness Center has attracted 715 members. The Fitness Center offers a variety of exercise programs, including a medically supervised exercise program for persons with chronic illness. Ninety-three individuals have participated in this particular class, several of whom are in their 80's. Many of these clients have had their medications decreased as a result of regular exercise. During the next few years, the Wellness Center will make the transition to a fully self-sustaining department of the Livingston Community Hospital, and almost all project activities are expected to continue.

Twenty-two outreach projects have focused their activities in rural schools, and most have found these sites to be effective places for service delivery. In many rural areas, the school is the hub of the community, making it a convenient place to provide health care services not only to children and adolescents, but to parents and other community members as well. The ***Rural Outreach Program for Elementary Students*** (Project 25) in rural eastern Kentucky, for example, provides comprehensive health and social services to children and their families. Although the project focuses on providing health care to children (it has provided almost 22,000 services for illness, injury, and screenings since its inception), it also offers family members services that include health screenings, monitoring of chronic health conditions, mental health care, and health education. In addition, a social worker provides classroom presentations on topics such as conflict resolution, decision making, suicide prevention, and self-esteem building. She also helps link children and their families with community resources to meet identified needs. This unique project has achieved a high level of support from the schools, parents, and the rural community.

Another school-based project, the *West Virginia Children's Health Project* (Project 77) in southwestern West Virginia, uses a fully equipped medical mobile clinic to deliver primary pediatric care to underserved children. The clinic, staffed by a pediatrician, a pediatric resident, and a pediatric nurse practitioner or licensed practical nurse, visits elementary schools and other host sites scattered throughout the region's rugged, isolated hollows. Since the project's inception, almost 1,800 children have received medical services. Most would not have received adequate care were it not for the outreach project.

While some projects have used mobile medical clinics to deliver needed health care services, others have addressed the distance barrier by transporting patients to distant health care. The *Care-A-Van* project (Project 73) in Price, Utah, for example, provides door-to-door service to medical appointments for seniors, individuals with disabilities, and others with chronic health conditions who cannot drive themselves. Drivers are volunteers who receive reimbursement from the program at 28 cents per mile. When the distances are especially long (a trip to a specialist may be 500 miles round trip), the project uses a series of drivers to cover different legs of the journey. Within a year and a half after receiving its demonstration grant, the project achieved self-sufficiency by securing mileage reimbursement contracts with the Southeastern Utah District Health Department, the Utah Department of Health Care Financing, the Disabled American Veterans and other private organizations.

Volunteerism is at the core of many of these outreach projects. The special skills required to recruit, retain, motivate and reward volunteers for a sustained period are not to be underestimated. One shining example of a volunteer-driven project is the ***Self Esteem Lifting for Families (SELF)*** project (Project 17) in Vandalia, Illinois. Originally, the Fayette County Health Department envisioned a small volunteer program for home visitation. This initial program eventually gave rise to a half dozen programs involving almost 200 volunteers and reaching more than 10,000 individuals. This constellation of programs, known as GEM (Volunteers Going the Extra Mile), recently won the Illinois Rural Health Association Exemplary Project award, and is in the final round for the Governor's Home Town award. Its coordinator has also won a five-county Senior Citizen's award for her contributions. The project's volunteer programs include home visitors (involving adult and junior high school volunteers), hospice, Mothers Outreach to Mothers (MOMs), Partners in Reading, and RNs en Route, a program in which retired registered nurses show health education videos to home health patients.

Other projects have recruited volunteer health care providers. The ***Healthlink*** project (Project 32) in Greenfield, Massachusetts has recruited 150 health care providers and advocates to provide free primary care services to low-income, uninsured and underinsured individuals at two walk-in clinics. This corps of physician volunteers has provided primary and specialty care to more than 1,637 individuals during the grant period.

Several projects have turned to new telecommunication technologies to bridge the distance barrier. These projects employ either satellite communications to transmit health education programs, or telephone lines that allow for two-way audiovisual interaction between a number of sites on a network. A state psychiatric hospital in southwestern Virginia, for example, uses an interactive video teleconferencing network to provide medication management to rural patients at seven remote outpatient facilities (Project 75). The technology has made a major difference in the ability of severely mentally ill patients to remain in their communities after discharge from the state hospital. It also allows for long-term medication management to be provided by the same psychiatrist. "This continuity of care simply has not occurred before within the public mental health treatment system in Virginia," writes the project director. The project has conducted more than 1,000 medication management appointments over the *Appal-Link* network, and will continue to provide this service after the outreach grant expires. Most importantly, patients participating in this program have experienced a significant decrease in repeat hospitalizations.

Almost every project offers some form of health promotion and education programming, either to the general public or to health professionals. This focus on education ensures lasting benefits to the community even if the project is unable to continue after the grant period. More than one-quarter of these projects provide continuing education opportunities to health professionals. And more than four-fifths offer public health education programs in addition to one-on-one patient education. These public education programs have covered almost five dozen health topics ranging from breast cancer prevention to farm safety to women's health concerns. The most common topics are nutrition, parenting, fitness, and teen issues.

The special needs of migrant and seasonal farmworkers have been the focus of seven outreach projects. One highly successful project involves the collaboration of a county hospital, a state department of health, and Pilgrim's Pride Industries (a chicken processing plant and a Fortune 500 corporation), whose economic growth has attracted a large number of immigrants to Mt. Pleasant, Texas, about an hour from Dallas. The *Prenatal Care Project: Cuidado Prenatal* (Project 69) has established a prenatal clinic to serve uninsured and underinsured Hispanic women in five counties. During the grant period, it has provided bilingual, culturally specific prenatal care services to more than 700 women, and health promotion information to more than 2,000. The clinic has become firmly established in the community, and has already made a measurable difference in the health of this population. The county hospital no longer sees women presenting for delivery as "walk-ins" in its emergency room, and the rate of out-of-hospital births has dropped from 8.5% to 2%.

The handful of programs mentioned above represents just some of the innovative outreach activities conducted by this industrious group of grantees. Together, they have filled a crucial niche in this nation's rural health care system, and will continue to do so for many years to come. Successful projects have worked hard to understand what is unique about their communities, paying close attention to local needs and values in developing their programs. This process is ongoing, and the benefits increase with time, for the better a project serves its community, the more likely it will gain long-term support. As these projects finish their outreach grants and move into the next phase of development, community support is probably the most valuable asset they could possess.

AIDS	Acquired Immune Deficiency Syndrome
CME	Continuing Medical Education
CPR	Cardiopulmonary Resuscitation
EKG	Electrocardiogram
ECT	Emergency Care Technician
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
HIV	Human Immunodeficiency Virus
STD	Sexually Transmitted Disease

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PROJECT 1

FRANKLIN COUNTY SCHOOLS MOBILE HEALTH CLINIC PROGRAM

Franklin County
School System,
Russellville, Alabama

Contact:
Nancy B. Lupton, CRNP,
Project Director

Franklin County Schools
Mobile Health Clinic
P.O. Box 610
Russellville, AL 35653
(205) 332-1360
(205) 331-0069 fax

Because good health is requisite to learning and educational achievement, the Franklin County School System initiated this mobile health clinic program to provide physical and mental health care and health education to each of the 3,523 students in its district. Before the school system initiated the outreach project, the schools in this rural Appalachian county had no health facilities, no health education materials, and health education was not taught in an organized manner to students.

To address these needs, the project purchased two 34-foot Allegro motor homes and converted them to health clinics. Between them, the two clinics visit all six school sites at least one day per week. On board, a nurse practitioner provides a variety of health care services, including immunizations, physical exams, follow-up of existing medical conditions, dental screenings, and simple laboratory tests. Students presenting with acute health problems and injuries are assessed, treated, or referred as needed. A social worker from the Riverbend Mental Health Center, a consortium member, provides mental health counseling and referral services twice monthly at each of the school sites.

Health clinic staff also conduct screenings for hearing, vision, and scoliosis. By May 1997, these screenings had resulted in the referral of 573 students for further vision evaluation and 211 students for further hearing evaluations.

Clinic staff also present a variety of educational programs, many in conjunction with students from the University of North Alabama School of Nursing, a consortium member. Project staff have also assisted in the review and purchase of a new comprehensive health education curriculum, "The Great Body Shop," designed for grades K-6 and now implemented in the schools.

As of May 1997, the mobile clinics had recorded more than 47,000 student contacts. These include almost 12,000 clinic visits, 19,000 contacts through educational presentations, and 16,000 contacts through screenings. These numbers far exceeded the expectations of the project's original visionaries. Parents continue to express their gratitude for the services their children receive.

Mindful of the barriers to health care that many families encounter, project staff conduct "vigorous follow-up" to ensure that each referred child receives appropriate treatment. Students whose families lack financial resources are offered assistance through a variety of organizations and agencies. For example, 76

FRANKLIN COUNTY SCHOOLS MOBILE HEALTH CLINIC PROGRAM

students have received vision evaluations and eye glasses through these organizations. The outreach project also has funded additional hearing evaluations by a certified audiologist.

One particularly innovative component of this project is its Parent Advisory Committee. Parents on this committee serve as advocates for the program and are instrumental in identifying services needed by the students.

Perhaps the greatest obstacle encountered by this project was resistance from local physicians, who were concerned early on that the mobile clinics would compete for their business. In response to these concerns, project staff visited each physician and provided written information about the project, answered questions, and sought their ideas and suggestions. These steps served to resolve the problem.

The consortium's nine members have each made essential contributions to service delivery and program success, writes the project director. Members are the Franklin County School System, the project's lead agency; Red Bay Hospital, a non-profit hospital; Columbia Northwest Medical Center, a private hospital; the Franklin County Department of Human Resources; the Northwest Alabama Regional Health Department; the University of North Alabama School of Nursing; the Riverbend Mental Health Center; the Southern Rural Health Care Consortium, a community health center; and Dr. Victor Norman, a family practice physician in private practice.

Much of this project's success can be attributed to the internal support provided by the schools. Because the school system designed and implemented the project, contact with principals, teachers, and students has been easy to establish and maintain. "If an outside agency had been responsible for program development and administration, if probably would not have been as easy to implement the program," suggests the director.

The Franklin County School System is committed to continuing the mobile clinics after the outreach grant expires. One scenario under consideration involves the school system funding one clinic, and contributions from other consortium members and county businesses for supporting the second clinic. The consortium is also seeking additional grant funds to support the program.

PROJECT 2

The state of Alaska has implemented an intense home visiting program for pregnant women and new mothers living within 30 miles of the village of Kenai. The project works closely with each client to determine her specific needs for health and social services, and then provides assistance through a series of home visits and referrals to other agencies. There is no charge for this service. Most clients have incomes below poverty level.

Families referred to the project are evaluated by the public health nurse and social worker to determine an appropriate plan of care. A family support worker then visits the home on a routine schedule, weekly at first and then less frequently as the family becomes more independent. The project's public health nurse and social worker also provides higher-level support and direction to the program.

In addition to family case management, the program also provides Well Child and Early Periodic Screening exams, immunizations, parent support groups, health education on topics determined by the family, and assistance in accessing needed health and social service agencies. As of May 1997, the program had served 78 pregnant women and 59 children in a total of 1,720 visits. About 10 mothers typically attend the monthly parent support group.

Eighteen non-profit and governmental agencies make up the project's consortium, led by the State of Alaska Department of Health and Social Service. Member agencies include the Department of Family and Youth Services, the Kenai Peninsula School District, the City of Kenai, the Kenai WIC nutrition program, and several community service groups. A handful of private citizens are also members. Consortium members assist in the project's planning and evaluation, as well as raise public awareness about its activities. The public health nurse organizes and leads all consortium meetings.

The consortium is currently seeking state funds to continue the program after the outreach grant expires. Members hope that funding will be provided by state sources such as the Healthy Families Fund or the Mental Health Trust Fund.

RURAL OUTREACH DEMONSTRATION PROGRAM IN KENAI, ALASKA

Alaska Department of Health and Social Service
Juneau, AL

Contacts:
Jo Andrew,
Regional Nurse Manager

Elaine McKenzie,
Deputy Chief

State of Alaska
Department of Health
and Social Service
Section of Public
Health Nursing
P.O. Box 110611
Juneau, AK 99811-0611
(907) 562-5454
(907) 562-7140 fax

PROJECT 3

WELLNESS ON WHEELS

Yavapai County
Health Department,
Prescott, Arizona

Contacts:
Marcia Moran Jacobson,
Director

Robert Moore,
Program Coordinator

Wellness on Wheels
Yavapai County
Health Department
930 Division Street
Prescott, AZ 86301
(520) 771-3122
(520) 771-3369 fax

The costs of delivering health and social services throughout Yavapai County, Arizona, have consistently posed a major challenge. The 8,123-square-mile county has a population density of 16.6 persons per square mile. Many barriers to health care exist, including few health care providers, inadequate facilities, low incomes, lack of insurance, and inadequate transportation. Wellness on Wheels is a mobile clinic that provides preventive health care services to six communities located throughout the county. Services are available to all county residents, but the project targets Hispanics, Native Americans, and individuals with low incomes.

What makes this mobile health clinic different from many others is the way it coordinates services using a variety of providers. Following the "one stop shopping" model of health care delivery, each consortium member contributes services to the project. This arrangement has resulted in a broad, multi-generational scope of health and social services available either on board the mobile clinic or through referrals to appropriate service providers.

The Yavapai County Health Department, the project's lead agency, oversees the day-to-day management of the project. It provides public health services such as child and adult immunizations, flu and pneumonia vaccinations, and family planning services. The Yavapai Family Resource Center oversees a child abuse prevention program and conducts in-home nursing visits to new parents. West Yavapai Guidance Clinic provides mental health screenings and counseling services. Adult Care Services, Inc., offers wellness screenings and other services for seniors. The Four County Conference on Developmental Disabilities provides advocacy for the developmentally disabled. The remaining member, the Yavapai County Department of Medical Assistance, conducts screenings for Medicaid eligibility.

As of May 1997, after almost two years of operation, the mobile clinic had provided preventive health services to more than 3,000 individuals. The project also had offered a variety of health education programs and had participated in health fairs and other community events to increase public awareness of the project and its services.

Because each community has different needs, the project has made community involvement a priority in the clinic's planning and development. Advisory committees in a number of communities have been formed for this purpose. Each service site also has a Community Outreach Representative who promotes the

WELLNESS ON WHEELS

program, identifies barriers to services, and develops community support. The project also has enlisted community organizations, schools, fire departments, and social service agencies to help guide the project's development.

The most important lesson learned by this project, writes the director, "is that it is difficult to get people to use preventive health services when treatment for health problems is not accessible. Economic and social conditions also pose additional barriers to well-being, and must be addressed by broad community efforts. We are only beginning to learn ways to adequately meet the health care needs of rural citizens in our county."

The consortium is pursuing a number of funding sources to sustain the mobile clinic after the outreach grant expires. These include private foundations, partnerships with area businesses, community fund-raising, and state funds (particularly the Tobacco Tax Mental Health Grant). At the very least, the Yavapai County Health Department will continue using the mobile health clinic to provide routine public health services in outlying rural communities.

PROJECT 4

THE DIVIDE WELLNESS CENTER

El Dorado County Public Health Department, Placerville, California

Contact:
Gayle Erbe-Hamlin, Director

El Dorado County Public Health Department
931 Spring Street
Placerville, CA 95667
(916) 621-6191

The six isolated rural communities scattered across the Georgetown Divide in California's Sierra Nevada Foothills have struggled for years to build continuity in their medical and social services. In the nine years before this outreach project, four physicians came and left because their practices could not sustain them financially and because of a lack of community involvement. In response to this problem, the El Dorado County Public Health Department established the Divide Wellness Center to provide comprehensive and integrated health and social services to the community.

The Divide Wellness Center and its consortium represent an unprecedented collaboration between the region's health and social service providers and the local school district. This strong partnership, led by the El Dorado County Public Health Department, includes Marshall Hospital, a private hospital; the Divide Community Services Network, an association of social service providers; and the Black Oak Mine Unified School District. The school district and the social service network provide crucial links to the community. Marshall Hospital provides the physical site for the center.

Clinical services provided by the center's public health nurses include primary care, limited chronic care, physicals, hearing tests, and limited laboratory services. Preventive medical services include immunizations, women's health, family planning, well child exams, testing and counseling for HIV and sexually transmitted diseases, and child health screenings.

The Divide Community Services Network provides social services, including substance abuse treatment, Medi-Cal and Medicare eligibility screenings, support services for victims of domestic violence, parenting education, and counseling services. The center's two Family Advocates work one-on-one with clients to help them connect with resources that address such needs as housing, employment, food, public utilities, child care, transportation, and clothing.

The project director writes that over time, the community has come to "own" the Divide Wellness Center. As of May 1997, the center had provided medical services to 6,200 of the region's 15,000 residents. The center now serves 500 patients per month with 25 new patients each week. Many clients are accessing preventive care for the first time. Others are seeking care earlier in the disease process. Yet another indication of success: the number of individuals inappropriately accessing primary care at Marshall Hospital's emergency room has declined 17% since the project's inception.

7

PROJECT 4

THE DIVIDE WELLNESS CENTER

One of the most distinguishing characteristics of the Divide Wellness Center is its broad concept of health and well-being, reflected in its integration of medical and social services. Providers of health and social services work together to provide "wrap-around" services for their clients. For example, a family who brings in a sick child might be referred to a Family Advocate to arrange for firewood delivery, or an individual attending parenting classes might be referred to a practitioner for a cholesterol test.

Perhaps the greatest challenge faced by the project was the development of this integrated approach to case management. It took time to foster the communication between providers that is necessary for this level of integration. To address this problem, all medical and social service staff were cross-trained on issues surrounding diagnosis and confidentiality. This training enhanced communication among the personnel and increased their comfort in referring patients.

According the project director, the collaboration between public, private, and civic organizations involved in the consortium is a first in El Dorado County. "The basis for this change," she writes, "is a collaborative spirit that places the client first and organizational needs second. This commitment to collaboration has lead to many innovative approaches in meeting client needs and overcoming barriers to integrating services."

After the outreach grant expires, the Divide Wellness Center will assume the designation of Rural Health Clinic, and Marshall Hospital will provide all billing services. The consortium is also exploring a number of reimbursement programs to financially anchor the center, including the Child Health Disability Program and Medi-Cal. Another possibility under consideration involves the Wellness Center becoming a health care provider for Foundation Health Plan and Kaiser Permanente.

The success of the Divide Wellness Center has lead the Public Health Department and Marshall Hospital to begin replicating the model in two other health clinics in the area.

PROJECT 5

HEALTHY FAMILIES/FAMILIAS SALUDABLES

San Benito
Health Foundation,
Hollister, California

Contacts:
Gregory L. Robinson,
Project Director

Raana Kashani,
Interim Executive Director

San Benito
Health Foundation
351 Felice Drive
Hollister, CA 95023
(408) 637-5306
(408) 637-9640 fax

Four chronic conditions have been particularly debilitating for U.S. Hispanics: diabetes, hypertension, high blood cholesterol, and depression. Familias Saludables was designed to address these conditions through prevention, education, and early intervention, using a family-centered intervention model. The project serves the Hispanic population in rural San Benito County, California, a group consisting primarily of migrant laborers, packing plant employees, and their families. About half of the residents in this county live in areas that lack any medical or ancillary health care services.

The project's health care team consists of a dietician/nutritionist, a registered nurse, and a community health outreach worker. The team screens prospective participants using blood pressure, blood cholesterol, and blood sugar checks, height/weight evaluations, and/or the Center for Epidemiologic Studies-Depression (CES-D) test. If an individual's scores fall within certain parameters, he or she is invited to become a participant in the program. Participants are given an initial full blood lab evaluation and follow-up evaluations at 6, 12, and 18 months. The project's health care team teaches participants and their families about healthy lifestyles using one-on-one patient education, seminars, pamphlets written in Spanish, and educational videotapes. Referrals are given to other agencies if needed.

The outreach project uses a mobile health clinic to provide services to migrant workers living in labor camps. The health care team also makes house calls to patients. Although time consuming, the house calls reach many who otherwise would not receive any medical care. They also help to include more of the family in the intervention. Finally, if participants are referred to medical care outside the county, Jovenes de Antano, a non-profit senior center and consortium member, provides transportation.

Participants with depression are provided with the services of a bilingual/bicultural mental health counselor and psychosocial outreach worker. Subsequent CES-D tests are administered at the provider's discretion to evaluate progress. Project staff also see that participants have transportation to counseling appointments, or they make house calls. For the treatment of diabetes, the project provides a glucometer (if prescribed by a physician) and teaches the participant how to use it properly. Two companies donated glucometers and test strips to the project.

As of May 1997, *Familias Saludables* had screened about 1,300 individuals for the program, most of whom were over 50 years of

PROJECT 5

HEALTHY FAMILIES/FAMILIAS SALUDABLES

age, Hispanic, and uninsured. More than 400 enrolled in the program and were seen beyond the first two visits.

Probably the greatest challenges to the project have been the migratory nature of its clientele. It is extremely difficult to conduct follow-up evaluations and promote healthy lifestyles over time to a group that arrives in May and leaves in November. Even when the migrant workers are in the area, their long working hours and 6-7 day work weeks make it difficult for them to find the time for follow-up evaluations, education, and treatment.

To address these challenges, the project instituted an incentive awards program, conducted home visits during the evenings, visited migrant camps and packing plants with the mobile health clinic, served food at seminars, and provided transportation to appointments.

The project's lead agency is the San Benito Health Foundation, a non-profit community health clinic. Other consortium members include the San Benito County Health and Human Services Agency; Jovenes de Antano; Hazel Hawkins Memorial Hospital, the area's only hospital; and the Seniors Council on Aging. Stanford University's Geriatric Education Center is overseeing the evaluation phase of the project, to be concluded August, 1998.

The project is currently applying for grants to continue services after the outreach grant expires. No project activities are expected to continue unless additional funding is received.

PROJECT 6

RURAL H ALTH OUTREACH GRANT PROGRAM
Southern Trinity Health Services, Mad River, California

Contacts:
Ann Webster, Administrator
(707) 574-6531
(707) 574-6534 fax

Jim Tinkelenberg, EMS Coordinator
(707) 574-6616

Southern Trinity Health Services
P.O. Box 4
Mad River, CA 95552

Southern Trinity Health Services in Mad River, California is the sole provider of health care in an area encompassing 800 square miles. Through this outreach grant, a certified rural health clinic has expanded and enhanced its primary care and social services, particularly in the issues of women's health, case management, and outreach. Residents of this area have fallen on hard times during the last decade due to a decline in the timber industry. High unemployment, extreme poverty, and a loss of hope and morale have contributed to an increase in social and mental health concerns. The strategy of this project has been to build upon the community's existing resources, namely a strong base of volunteers, and a network of regional health and social service agencies brought together under the grant's consortium requirement.

Under the grant, the clinic has added a second mid-level practitioner to provide much needed women's health and perinatal services. Access to immunizations and other children's services has also improved. The clinic also provides case management for patients with chronic disease, and home health outreach and mammograms for residents of the outlying areas of Zenia and Kettenpom.

The project's other consortium members have expanded their social and mental health services and integrated them with the clinic. The Healthy Start Collaborative provides counseling services, family advocacy, and parenting education for the project. An eligibility worker at the clinic assists individuals in applying for Medi-Cal and other public assistance programs. The Human Response Network, another consortium member, trains community volunteers to provide social and mental health support services and crisis intervention. The agency also offers counseling services, food distribution, and safe shelter services to victims of domestic violence. Finally, a collaboration of community groups assists residents in job search and application activities.

One of the most innovative components of the project has been the development of a telecommunications system designed for telemedicine, distance learning, and teleconferencing. This low-cost system uses regular phone lines and allows for interactive video and audio communication between the clinic and remote sites. As of May 1997, the project had used the system to provide emergency medical services training and certification courses (otherwise unavailable in the service area) to more than 30 individuals. The project also had used the system to link 35

PROJECT **6**

RURAL HEALTH
OUTREACH
GRANT PROGRAM

community residents with distant medical providers for diagnosis and treatment consultations.

The region's geographic isolation and weak economic base have made community volunteerism one of the project's most valuable resources. The project has trained 82 community residents as either First Responders, Emergency Medical Technicians, or medical dispatchers. More than 170 community residents have participated in CPR classes. Volunteers have also been trained in community outreach, health education, facilitation of support groups, and crisis intervention. Other community members provide clerical and administrative support in the clinic.

Efforts to encourage volunteerism in youth have lead to the implementation of a modified First Responder course and a "Junior Trauma Team" for local high school students. In addition to providing hands-on training, project staff hope that the course will spark career interest in emergency medicine. Students have also been brought onto the Board of Directors to contribute to project planning.

One obstacle faced by the project has been the long travel times between consortium members, making it difficult for the entire consortium to meet frequently. Southern Trinity Health Services, the project's lead agency, is based in Mad River, as is the Healthy Start Collaborative. The Human Response Network is located in Weaverville, an hour away, and Northcoast Emergency Medical Services, the final consortium member, is based in Eureka, which is two hours from Mad River. The consortium has overcome this obstacle through the use of teleconferencing.

Almost all project activities are expected to continue after the grant period. Funding will come from a variety of sources, including patient fees, funding from Trinity County, local fund raising efforts, and support from local and regional foundations. The area's social and emergency medical services will continue to rely heavily on the participation of community volunteers. The consortium will also continue to support project activities, but will operate with less structure.

PROJECT 7

Because Fremont County, Colorado, has a higher than average population of individuals over age 65 as compared to other counties in the state, this outreach project has focused on the needs of the homebound elderly. The project has implemented four distinct programs benefitting the elderly and disabled. All have been embraced by their communities and are expected to continue after the grant period.

The most unusual program offered by the project is its Eldercamp, a weekend-long camp for the elderly and disabled. Its intent is to provide a socialization experience to isolated and homebound individuals, while meeting their daily needs for health and supportive care. The camp also provides caregivers with a needed respite.

There is considerable risk in assuming 24-hour responsibility for these elderly individuals, and project staff must coordinate multiple entities to accomplish a safe and successful camp. Priority is placed on screening applicants and volunteers for appropriateness, and on preparing to meet their needs in a non-traditional environment. This involves not only arranging the services of a full-time physician, but also procuring the appropriate location, necessary equipment, emergency drugs, oxygen, transportation, and adequate caregivers. "A second challenge," writes the project director, "is gaining the trust of the primary caregivers who, although they may be in need of respite, are by its very nature, ingrained in a relationship of mutual dependence."

Eldercamp has received overwhelmingly positive responses from campers, their families, and volunteers. It is offered twice yearly, with about 8-11 campers and 15-20 volunteers participating each session. A 15-minute promotional video is available for those interested in duplicating the program.

The project has also implemented a Continuing Care program that provides personal care, light housekeeping and home repairs, and telephone reassurance to the homebound elderly. It also provides respite to caregivers. This program currently serves 38 clients and provides an average of 1,000 hours of in-home care per month. Its greatest benefit is that it allows individuals to remain safely at home, bypassing higher and more costly levels of care. The program is nearly self-supporting through Medicaid, third-party reimbursement, and private payments.

ST. THOMAS MORE HOSPITAL RURAL HEALTH OUTREACH DEMONSTRATION PROGRAM

St. Thomas More Hospital,
Canon City, Colorado

Contact:
Nancy J. Kellner,
RN, BSN, MPA,
Home Health Director

St. Thomas
More Hospital
1338 Phay Avenue
Canon City, CO 81212
(719) 269-2294

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PROJECT **7**

ST. THOMAS MORE HOSPITAL RURAL HEALTH OUTREACH DEMONSTRATION PROGRAM

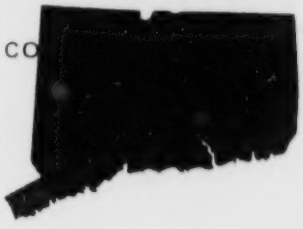
The Wellness Van, another outreach program, was established to provide health education and health screening to elderly individuals in eight rural communities throughout the county. The program uses the Testwell Health Risk Appraisal, the Healthwise for Life book and the Personal Wellness Record (developed by outreach project staff) as its primary tools for teaching responsibility for one's health. The success of this program is due in large part to the trusting relationships built with community leaders during its implementation. These individuals have generated considerable support and participation within their communities.

The project has also developed and distributed the Fremont County Human Services Directory, a listing of public and not-for-profit health service organizations. The directory is intended to assist service providers in making referrals, and is the most accurate and comprehensive listing ever available in the county. When a resource is not available locally, the directory lists regional and national organizations.

Leading the project's consortium is St. Thomas More Hospital. Other participants include the Canon City Business-Education Alliance, which provides a pool of potential student volunteers for the project's intergenerational programs. The project in turn offers students an opportunity to experience health related careers. The Canon City Ministerial Association, an association of local ministers, recruits additional volunteers through their churches. The ministers also refer isolated elderly individuals who may benefit from its programs. Completing the consortium is the Fremont County Friendly Visitors, a not-for-profit volunteer organization.

All project activities are expected to continue after the outreach grant expires. St. Thomas More Hospital will fund the Wellness Van and a revision of the Human Services Directory in two years. The Continuing Care program will continue with reimbursement through Medicaid, private insurance, and private pay. Lastly, Eldercamp will be supported by other grants, contributions from campers and local service organizations, and donations through the St. Thomas More Foundation.

PROJECT 8



ELDERLY RURAL HEALTH OUTREACH

Day Kimball Hospital,
Putnam, Connecticut

Contact:
Lucinda Hogarty, MPH,
Director of Health

Northeast District
Department of Health
P.O. Box 145
Brooklyn, CT 06234
(860) 774-7350
E-mail:
hoga103w@wonder.em.cdc.gov

A consortium of five established providers of primary and mental health care in rural northeastern Connecticut has created a large number of new programs and services for the elderly with this outreach grant. In addition to providing increased services, the consortium has been instrumental in improving referral patterns and communication between providers. Project staff feel that this, in turn, has led to better outcomes for clients.

Programs supported by the grant fall under the general categories of outreach and casefinding; assessment, referral and coordination of services; and physical and mental health promotion. Support for these activities comes from the outreach grant and from in-kind support provided by consortium members. Heading the list is a community-based senior wellness clinic that offers health education and exercise programs. An attorney also provides free counseling and education sessions concerning insurance, living wills, probate, and conservator issues at eight locations in the community. Almost 2,000 seniors have received these legal services.

In the area of outreach and casefinding, a licensed practical nurse has been trained to identify the needs of elderly patients leaving the hospital. A community outreach worker then contacts the patient and helps link him or her with appropriate support services. The project has served 64 patients in this manner, following their progress throughout the grant period or until the need is met. Other grant activities have focused around the needs of those with poor vision, particularly the need for improved public transportation.

In yet another grant activity, a teacher/writer has researched, compiled, and analyzed intergenerational programs throughout the nation. The published resource guide is intended to aide teachers and senior activities directors in starting new intergenerational programs.

Finally, the long list of grant-supported activities includes a peer companion program (696 contacts) and a telephone reassurance program (2,166 contacts); geriatric nurse practitioner home visits (178) and clinic visits (454); registered nurse diabetic testing, counseling, weight monitoring, and foot care; mental health assessment, counseling, and referrals (50 contacts); bereavement support; delivery of meals to homebound elders (329 meals); and an intergenerational socialization and arts program called Silver Spirit (319 contacts).

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PROJECT 8

ELDERLY RURAL HEALTH OUTREACH

The positive influence of this outreach project on interagency communication has been observed, not just among consortium members, but among other agencies and providers in the community as well. This ripple effect has been attributed to the credibility and visibility given the interagency approach by the outreach grant, and to the good press the grant activities have received in the community. The impact on patient outcomes, of better communications and improved referral patterns will be studied during the evaluation phase of the project.

The project's consortium meets bimonthly and is comprised of the Day Kimball Hospital, the project's lead agency; Community Health and Home Care; the Quinebaug Valley Senior Center; an attorney specializing in legal issues affecting the elderly; Elderly Nutrition Service, which provides Meals on Wheels; and United Services, a community mental health center.

As the outreach grant period draws to an end, several grant activities have been integrated into the operations of various consortium members to ensure their continuation. For example, the link between the hospital's discharge process and community outreach services has become an established part of the hospital's nursing protocol. Support activities for those with poor vision will also continue with in-kind support from the hospital.

PROJECT 9

RURAL ACCESS PROJECT
Children & Families First,
Georgetown, Delaware

Contacts:
Dee Davis,
Program Manager
(302) 856-2388 ext.107

Francis "Bud" Lewis,
Director
(302) 856-2388 ext.102

Children & Families First
410 South Bedford Street
Georgetown, DE 19947

When several concerned agencies in rural Delaware met a few years ago to discuss the area's high rates of infant mortality and low birth weight, there was strong consensus that the problem was not a lack of available services, but a lack of participation and access. The Rural Access Project was therefore designed to improve access for low-income pregnant women in Kent and Sussex counties. Gradually, the project expanded to include all low-income residents of the two counties in need of medical and social services.

The reasons why low-income individuals do not access available services are many and varied, and this project made a point of addressing as many of these reasons as possible. The project offers transportation to medical or social agencies; referrals to food, housing, and other services; assistance in filling out forms; case management; and advocacy. As of May 1997, the project had assisted 12,000 clients, 244% over their projected goal. Almost all clients are uninsured or underinsured.

One of the project's most significant problems during its implementation was a lack of understanding by other local agencies of the purpose of the project. Many agencies initially perceived the outreach project as competition. The project had to work hard to convince these agencies that they could gain something through cooperation, in particular a reduction in their "no-show" rates. Eventually, cooperative and trusting relationships were formed. The project now communicates regularly with agencies concerning client progress, and how to better meet client needs.

Other significant challenges were the barriers to care faced by the large Hispanic population in these two counties. Language differences and legal and immigration concerns resulted in a significant lack of participation in the health care system. The project's initial attempts to recruit Spanish-speaking volunteers or hire a bilingual staff person were unsuccessful. Consequently, the project's presence in the community early on was not as strong as it might have been. It also didn't help that the project's vans were painted the same color as the immigration service's. Two bilingual staff persons were eventually hired, and they have made remarkable improvements in reaching this population.

As the lead agency, Children & Families First provides office space for the project's director, program manager, community specialist, and case manager/advocate for Sussex County. The

PROJECT 9

RURAL ACCESS PROJECT

Perinatal Association of Delaware houses the case manager/advocate for Kent County. Turnabout Counseling & Community Services completes the consortium.

Children and Families First has been allocated state funds to continue the Rural Access Project after the outreach grant period. It is also applying to become Medicaid reimbursable. Fundraising events and a sliding fee scale for those with no insurance are also planned. All project activities are expected to continue after the grant period.

INJURY PREVENTION AND SAFETY PROJECT

Ninth District Opportunity, Inc., Gainesville, Georgia

Contacts:
Janice A. Riley,
Executive Director

Brenda Reeves,
Project Director

Ninth District
Opportunity, Inc.
810 Pine Street
P.O. Drawer L
Gainesville, GA 30503
(770) 532-3191

The Injury Prevention Project was designed to reduce the rate of home injuries for the elderly living in 12 rural counties of Georgia. Injury prevention counselors working for the project visit the homes of the elderly and provide safety and personal health assessments, education, and safety repairs. Ultimately, project staff hope that these activities will help the elderly in this rural area maintain independence in their homes.

The project employs two full-time injury prevention counselors, one part-time repair person, and several part-time volunteer safety assessors. All personnel participate in a 40-hour training program and are given follow-up sessions as needed.

As of May 1997, the project had provided direct services to 1,166 older adults through identifying and eliminating safety hazards in and around the house. The most common recommendations are the posting of emergency phone numbers and the installation of tub strips/bath mats, smoke detectors, grab bars, night lights, flash lights, and/or no-slip underpads for rugs.

In addition to identifying safety hazards in the home, counselors are also trained to identify health problems by asking the individual about their health and observing their functional abilities. When health problems are identified, the individual is referred to the appropriate community resource.

One of the project's most successful components is its "House Mouse Safety at Home" curriculum for children in the Headstart Program. The curriculum includes classroom activities and some homework in which students are encouraged to share what they have learned with their parents and grand parents and to complete a home safety check and emergency number card with an adult. Teachers and students have responded favorably to the curriculum.

The project's lead agency is Ninth District Opportunity, Inc., a community-based, private non-profit agency. The University of Georgia Center for Continuing Education and the Georgia Department of Human Resources complete the consortium.

The project has also developed a community-wide, 25-member Injury Prevention Consortium to advise project staff, provide referrals to the program, and increase community awareness of injury prevention. Consortium members represent home health agencies, extension services, adult protective services, family and children's services, and fire departments. The group has made substantial contributions to the project, writes the direc-

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INJURY PREVENTION AND SAFETY PROJECT

tor. By incorporating injury prevention into the services offered by their respective agencies, the group also has permitted the continuation of project objectives after the outreach grant.

The project will continue its public education activities after the outreach grant expires through participation in injury prevention festivals and the distribution of educational materials. Funding for future injury prevention projects will be sought from local government, businesses, and other grant sources.

PROJECT **11**

MOBILE MEDICAL UNIT PROJECT

Tanner Medical Foundation,
Carrollton, Georgia

Contacts:
Denise L. Taylor,
Executive Director
Tanner Medical Foundation
303 Ambulance Drive
Carrollton, GA 30117
(770) 836-0853

Lori Harris,
Program Director
Community Care Program
710 Dixie Street
Carrollton, GA 30117
(770) 836-9197

In 1993, generous community support allowed the Tanner Medical Center to establish a Community Care Program to provide medical, dental, and preventive care to the medically underserved in Georgia's Carroll and Heard counties. The program used funds from a 1994 rural health outreach grant to add a Mobile Medical Unit Project to help overcome the financial and transportation barriers still encountered by its target population. During the last two years, the Community Care Program has received two prestigious awards, which have identified the mobile medical clinic as an impressive program component. In 1996, the Georgia Rural Health Association selected the program as the Rural Health Program of the Year, and in 1997, the program was selected as the fifth runner-up for the Monroe E. Trout Premier Cares Award.

Since its inception, the mobile clinic has visited 75 sites throughout the community, including city and county schools, housing projects, shopping centers, and churches. On board the clinic, a nurse practitioner provides health checks; immunizations; hearing and vision tests; and screenings for diabetes, breast cancer, high cholesterol, and hypertension. Patients identified as hypertensive are also provided follow-up care and support through the clinic. Finally, a group of local dentists and hygienists provide dental care on a volunteer basis, significantly improving this community's access to dental care.

As of May 1997, the project had served more then 21,000 individuals. Project staff have provided roughly 6,000 hypertension screenings, 4,500 diabetes screenings, and 3,000 dental screenings for children. Since the project began, it also has immunized nearly 4,000 children, increasing the number of two-year-olds adequately immunized in Carroll County by 40%.

The Community Care Program has received grant monies from two other funding sources, allowing for the implementation of two additional preventive care programs performed through the mobile clinic. A grant from the Susan G. Komen Foundation has supported the Breast Cancer Screening and Education Project, through which indigent women ages 35-50 receive instructions on breast self-examination, preventive education, clinical screenings, and free mammograms. A grant from the Delta Airlines Foundation has supported the Community Health Assessment Project, through which more than 4,000 area residents have received health assessments, preventive screenings, and comprehensive follow-up reports. Both projects have complemented the Mobile Medical Unit Project, and have helped to enhance its presence in the community.

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PROJECT **11**

MOBILE MEDICAL UNIT PROJECT

Leading the project's consortium is the Tanner Medical Center. Other consortium members include the Community Care Program; the Carrollton Board of Education; and the Departments of Health, Family and Children's Services, and Boards of Education for Carroll and Heard Counties. The consortium has been instrumental in scheduling events, referring patients, and promoting the project.

The Tanner Medical Center plans to support all project activities after the outreach grant expires. The Tanner Medical Foundation will also continue to identify and pursue other grant opportunities.

PROJECT **12**

RURAL SCHOOL-BASED HEALTH DISTRICT CONSORTIUM/ SCHOOL HEALTH OUTREACH PROGRAM

Tattnall County
Board of Health,
Reidsville, Georgia

Contacts:
Tarry Rogers,
Program Coordinator
School Health
Outreach Program
P.O. Box 430
Reidsville, GA 30453
(912) 557-7952
(912) 557-7954 fax

John Ted Holloway, MD,
Medical Director
Southeast Health District
Tattnall County
Board of Health
P.O. Box 426
Reidsville, GA 30453

In 1992, community leaders in Tattnall and Candler Counties, Georgia, formed a grassroots consortium called Community Decision Making to involve local citizens in addressing the barriers to health care in their community. In addition to a lack of primary care providers, families in this impoverished rural area faced many obstacles to health care, including long distances to care, lack of transportation, costs, cultural isolation, and lack of awareness. At a town meeting, the consortium determined that a school health program was the best possible mechanism to expand access to health care for children and young adolescents. In 1993, the consortium received a rural health outreach grant to implement its School Health Outreach Program.

The outreach program has placed a public health nurse in each of four elementary schools to provide preventive and primary health care services to children. The American Academy of Pediatrics' recommended goals for School Health Policy and Practice serve as a guide for implementing the project. On any given day, the duties of the nurses range from giving medications, attending to an acute illness or injury, counseling a student, screening for vision and hearing, to making referrals to private health care providers for dental, eye, and mental health care. The nurses also provide health information in the classroom and administer health checks to students who have parental permission.

The four nurses see an average of 1,050 students each month. As of May 1997, the project had served more than 21,000 children in grades K-8. Roughly one-third of the students are African American.

One unique aspect of this program is that the nurses treat not just the health problem presented at school, but they also make every attempt to provide referrals and address the factors contributing to the health problem. The program's coordinator provides direct social services to children referred by the school nurses, linking them with appropriate services and providers, helping them with family problems, finding funding for glasses or orthodontic braces, and providing transportation to and from health care providers, which can sometimes be up to 100 miles away.

Leading the project's consortium is the Tattnall County Board of Health. Other members include the Candler County Board of Health, the Tattnall and Candler Counties' Boards of Education, Tattnall Memorial Hospital, Candler County Hospital, and Georgia Southern University. An advisory council also provides

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RURAL SCHOOL BASED HEALTH DISTRICT CONSORTIUM/ SCHOOL HEALTH OUTREACH PROGRAM

guidance and suggestions to the consortium. Members of this council include representatives from the Department of Family and Children Services, the County Extension, PTA Presidents, Migrant Health Services, and the director of Pineland Mental Health.

Project staff feel this program could be successfully duplicated in other rural areas, provided that the school and public health systems have a strong collaborative relationship. The public health nurses must also receive a great deal of support from the Board of Public Health, Medical Director, and staff in their districts, as is the case in Georgia.

School-based nursing services are expected to continue after the outreach grant expires through Medicaid reimbursement and support from the Board of Education and Board of Health.

PROJECT **13**

RURAL HEALTH OUTREACH — COMMUNITY CLINIC OF MAUI

Community Clinic of Maui, Kahului, Hawaii

Contacts:
Carlayna Nakamura, Executive Director
(808) 871-7772 or
(808) 872-4017

Nancy Vendetti, Social Services Director
(808) 871-7772 or
(808) 872-4011

Community Clinic of Maui
48 Lono Avenue
Kahului, HI 96732

People captivated by the beauty of Maui often fail to recognize that there are individuals unable to access even basic medical and social services. Some are immigrants, unable to speak or read English, who find Western medical institutions inaccessible. Others live in small, remote villages, more than 30 minutes from the nearest primary care provider. Still others are poor, elderly, or homeless.

This outreach project was designed to address the needs of Maui's disadvantaged population through two methods. The first was to expand primary care services available through the Community Clinic of Maui. The second was to maximize existing services and prevent duplication by integrating the island's health and social service providers. At the time the grant was awarded, the Community Clinic of Maui was one year old and the island's first and only clinic to accept patients regardless of their ability to pay. The consortium formed under the outreach grant also was the first of its kind on the island.

Before this outreach project, the Community Clinic of Maui saw about 100 patients per month. The hiring of a physician, a family nurse practitioner, a social worker, and three bilingual outreach workers greatly expanded the clinic's capacity. What followed was a skyrocketing of patient contacts/visits to 2,200 per month. Ironically, this unanticipated growth and strain on the clinic's physical space presented the biggest challenge to the project. In response, the project opened a new clinic in January 1996 to replace the old one, and began two satellite clinics as well.

Services provided at the clinic include primary care; short-term counseling services; substance abuse services; translation in Spanish, Tongan, Ilocano and Tagalog; counseling for patients who are not complying with medical treatment; assistance in accessing QUEST (Hawaii's Medicaid managed care program); and case management. The project also provides financial assistance to qualifying patients for critical medications, laboratory work, and/or radiology.

Because of the comprehensive referral mechanism developed through the consortium, project staff can also refer clients to an array of other health and social services. Some of these include nutritional education and WIC nutritional services, long-term counseling for the mentally ill, elderly services and referrals, health care and outreach to the homeless, and health education to Native Hawaiians concerning diabetes and hypertension control and prevention.

PROJECT **13**

RURAL HEALTH OUTREACH — COMMUNITY CLINIC OF MAUI

The project has far exceeded its goals. As of May 1997, the clinic had provided more than 35,000 patient visits/contacts to 15,750 individuals. Almost 90% of clinic patients have incomes that are low enough for them to be eligible for social assistance services. They represent a broad variety of ethnic backgrounds, including Caucasian, Native Hawaiian, Filipino, Hispanic, and Tongan or other Pacific Islander. English is a second language to at least 25% of the individuals.

Project staff feel that this model of continuum/networking, which uses outreach to help residents use existing services appropriately, has proven extremely successful. "Decreased competition and lifelong relationships between agencies have developed as a result of the Rural Health Outreach Grant," writes the project's director. "With limited resources, everyone has benefitted by the formation of strong and lasting communication networks, improved referral mechanisms and patient outcomes, less inappropriate use of emergency services, and better follow-up and continuity of care."

One of the project's most difficult challenges was the tracking of some patients and referrals, particularly for the homeless. New software purchased in July 1995 has helped solve this problem by maintaining demographic information. "We have learned that documentation and consistent demographic tracking of clients is vitally important when evaluating one's program," writes the project director. "Ideally, these tracking programs should be set up before the program starts."

The original agencies in the consortium included the Community Clinic of Maui (the lead agency), Public Health Nursing, Hui No Ke Ola Pono (Native Hawaiian health system), Malama Na Makuahine (perinatal case management), Maui Economic Opportunity, and the Office on Aging. As the grant progressed, the project added several new agencies to the consortium, including the Maui AIDS Foundation, the Salvation Army, Maui Kokua Services and Maui Family Support Services.

The consortium also has served as the incentive for the Maui Community Care Hui, a new network of more than 45 Maui businesses and health and social services agencies working toward building more seamless systems of care. This new consortium, into which the rural health outreach consortium has been absorbed, is now receiving statewide recognition for bringing agencies together for vertical and horizontal integration, increasing the capacity and quality of services, and decreasing

costs and duplication. "We never anticipated serving as the role model for this network," writes the project director. "There has been unanticipated enthusiasm and support for the consortium concept and the vertical integration of services."

All project activities will continue after the outreach grant expires. The salaries for the clinic's staff will be supported through state Purchase of Service contracts, third-party reimbursement, a grant from Maui United Way, and QUEST. Additional funds will be raised through risk pool settlements from the Medicaid managed care plans and other foundation grants and fundraising.

RURAL HEALTH OUTREACH — COMMUNITY CLINIC OF MAUI

Idaho's population is one of the youngest in the country—those aged between 5 and 24 represent one-third of the population. Consequently, the health and social problems of teenagers are of particular concern. To address the needs of this growing demographic group, the University of Idaho has implemented a school-based, comprehensive health education program for high school students. The project emphasizes physical health screenings, health education, health promotion, mental health counseling, and other preventive health measures. Thirteen rural high schools in southeastern Idaho have elected to participate in the program, creating a target population of 4,355 students, their families, and 300 faculty members.

One of the project's major objectives has been to provide and interpret Health Risk Appraisals to the students and faculty in the targeted school districts. The purpose of this survey is to teach participants to assume personal responsibility for their health and to increase interest in adopting healthy behaviors. An RT2000 Computer Scanner, purchased by the project, reads the health risk appraisals and generates a personalized health report. In addition to health risk appraisals, the scanner's software also supports nutrition, stress, smoking, alcohol, and breast care assessments.

Other physical health services provided by the project include school-based screenings for blood pressure, blood cholesterol, and hearing in school districts where these screenings were not previously available.

The project's mental health activities have drawn upon a combination of professionals and student interns provided by Idaho State University's Department of Counseling, a consortium member. Counselors give group presentations to classrooms and then form therapy groups for interested students. Individual counseling sessions are also provided. Referrals to the program come from classroom teachers, resident school counselors, administrators, and student self-referrals. As of May 1997, the project had provided mental health counseling services to 515 students in more than 2,800 counseling sessions.

In its health education and promotion component, the project has provided classes, seminars, and workshops on a variety of topics identified to be of priority need and interest to high school students. The project also has put on a school health fair or other health promotion activity in each of the thirteen communities. As of May 1997, more than 1,100 students had received health education and Health Risk Appraisals, and 1,170 students had

SCHOOL-BASED HEALTH ENHANCEMENT PROJECT

University of Idaho Cooperative Extension System, Preston, Idaho

Contacts:
Lynn R. Harris, Extension Educator

Maureen Reigger, CES, District IV Secretary

University of Idaho Cooperative Extension System, Franklin County
51 West Oneida
Preston, ID 83263
(208) 852-1097

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SCHOOL-BASED HEALTH ENHANCEMENT PROJECT

participated in health fairs. Finally, a regional health directory has been developed and distributed through the region's county extension offices.

The most significant lesson learned by this project is that evaluation is critical for effective planning. "Evaluation should start early in the project," writes the project director, "and it is worth hiring an evaluation consultant who will follow the project from start to finish."

The project's consortium is led by the University of Idaho Cooperative Extension System, located in Idaho Falls, which oversees the health promotion and health education components of the project. The remaining two members, both located in Pocatello, are the Southeastern District Health Department, which provides physical health screenings, nutritional assessments, and referrals to health care providers; and the Idaho State University Department of Counseling, which provides the mental health services.

Almost all project activities are expected to continue after the outreach grant expires. The project's physical health activities will continue under contracts with the health department and school district, and the Cooperative Extension System will support the project's health promotion activities. The school district and county government will support one professional mental health counseling position, and several interns also have been hired for school counselor positions.

PROJECT **15**

RIVER TO RIVER CONSORTIUM
Perry County Counseling Center, Du Quoin, Illinois

Contact:
John Venskus,
Project Director

Perry County Counseling Center, Inc.
East Jackson Street
P.O. Box 189
Du Quoin, IL 62832
(618) 542-4357

The River to River Consortium in southern Illinois was formed to provide more consistent professional services to individuals experiencing a mental health crisis. At the time this outreach project was implemented, there was an extreme shortage of licensed mental health professionals in the southern third of the state. These professionals were concentrated in several agencies and not available throughout the region. More than half the agencies had no licensed staff available for crisis situations, and none of the agencies provided professional crisis intervention seven days a week, 24-hours a day.

All but two of the region's community-based mental health clinics participate in the consortium, as well as five public health departments and one independent alcohol and substance abuse treatment provider. Together, the twenty agencies serve almost 668,000 people residing in 33 rural counties. This large rural area is diverse both culturally and economically, ranging from the prosperous community of Carbondale to underserved, African American communities in Pulaski and Alexander counties. The highest unemployment rates in the state — some of which are in the double-digit range are found in the counties served by the consortium. "It would be very difficult to find an area whose people could benefit more from a Rural Health Outreach Grant than this one," writes the project's director.

The consortium's goal was to create an enhanced, coordinated system of emergency mental health care through the integration of existing services. Its first activity was to create an 800 telephone number to connect all members of the network with an emergency 'on call' consulting psychiatrist, available 24 hours a day. The project's second component, implemented in 1995, is an in-home psychiatric nursing service for elderly, disabled, or other homebound individuals who are unable to travel to psychiatric services.

The telephone system was initially conceived so that community-based crisis intake workers could consult with an on-call psychiatrist, thereby improving crisis intervention in these underserved communities. However, as of May 1997, the telephone system had facilitated only 300 psychiatric consultations, a much lower number than expected. One reason for this may have been that the agencies are so accustomed to working without psychiatric backup that they continue to operate as they always have, despite efforts to train the staff in accessing the on-call psychiatrists. The system might have been more effective if

RIVER TO RIVER CONSORTIUM

the crisis intake workers had had ongoing relationships with the psychiatrists.

As it turned out, most of the requests for consultation came from contract emergency room (ER) physicians who deal with psychiatric patients presenting at the ER with concomitant medical problems. In these cases, the ER physician often must decide whether to place the patient in a psychiatric facility for further evaluation — a decision that requires a familiarity with mental health issues and the laws regarding involuntary placement of the mentally ill. The telephone system allowed the ER physician to consult with a psychiatrist when faced with this complex decision.

The project has brought several indirect benefits to the area, in particular the formation of a network of mental health providers and enhanced recruitment of mental health professionals. Six new psychiatrists have begun practicing in the region since the grant was implemented, attributed in part to the availability of on-call support after hours. The number of licensed professionals providing intervention services also more than doubled during the grant period.

The project's second component, the psychiatric home nursing service, encountered several obstacles in its implementation. Member agencies were reluctant to provide the service, and it was difficult to manage the program over such a large geographic area. Eventually, the project's lead agency created its own non-profit home health agency — Medicare licensed and JCAHO accredited — which provides psychiatric home nursing services in addition to traditional home health services. Since its inception, the agency has provided 720 psychiatric consultations a year. Consortium members refer patients to the program and provide consultation for the certified psychiatric nurses.

Because mental illness often prevents people from seeking help and is exacerbated by isolation, the psychiatric home nursing program has proven an ideal way to provide services to these individuals. The program also has facilitated the identification and treatment of depressed and anxious patients who are recovering from strokes and other physical conditions. The program's start-up costs, however, and the sheer size of the area served, continue to present difficulties. In retrospect, writes the project director, "it would have been easier to find a partner that was already a licensed home health agency. The program can operate at a near break even basis if services are offered through

contract staff residing throughout the target area. The size of the area needs to be carefully considered so that travel does not diminish the effectiveness of the program."

The River to River Consortium will continue to support the telephone consultation service after the outreach grant expires. The new home health agency will also continue to provide its psychiatric home nursing service, despite the fact that the long travel distances involved make it a marginal enterprise. The agency offers a full range of home health services that are reimbursable by Medicare and Medicaid, and these will support the less profitable psychiatric nursing component. The project also expects some reimbursement from private insurance companies for home nursing and psychiatric consultation

The need for medical services in five Illinois farming communities had reached a state of emergency when this outreach project began. For the 5,500 residents of this area, the nearest physicians were 30-40 miles away, and were either close to retiring or no longer accepting new patients. Lack of transportation and inadequate health insurance coverage also prevented many citizens from seeking routine medical care. After researching the health care needs of the community, the consortium decided to adopt the "one stop shopping" model of service delivery — to provide medical services, public health programs, and mental health counseling at a central location accessible to the entire community.

The project's primary goal, and probably its greatest challenge, has been to establish full-time medical services in the five-community area. Several successful recruitments have made this goal a reality. In June 1996, a hospital placed a full-time physician assistant in a rural health clinic located 15 miles away from the service area. In addition, a physician has started practicing in the service area one day per week, and two nurses who recently completed the requirements for women's health nurse practitioner certification are now conducting women's health and family planning clinics at the health department. By the end of the grant period, a local hospital plans to open a second rural health clinic site also staffed by a mid-level practitioner.

In addition to women's health and family planning services, the health department also provides health screenings, immunizations, WIC, mental health counseling, and home visits to pregnant women, infants, and seniors. The Chore Housekeepers program, another project activity, provides light house cleaning, meal preparation, and laundry for seniors and the disabled who need help living at home. The project also has implemented scoliosis screening at three school districts, and compiled and distributed a social services directory.

One hundred individuals attended the project's Health Fair, which offered free cardiovascular health screening. Follow-up health education sessions were well attended. They covered exercise, nutrition, stress management, cancer, smoking cessation, and diabetes control. As a result of these outreach activities, use of physician assistant services at the rural health clinic increased by 50%.

As of May 1997, the project had provided medical services to 3,454 individuals, public health services to 3,760 individuals,

RURAL HEALTH OUTREACH NETWORK
Fulton County Health Department,
Canton, Illinois

Contacts:
Jan McCubbin,
Health Services Director

Gary Zaborac

Judy Juraco

Fulton County
Health Department
700 East Oak Street
Canton, IL 61520
(309) 647-1134

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RURAL HEALTH OUTREACH NETWORK

and mental health counseling to 277 individuals. More than 700 have received housekeeping services.

One benefit of the "one stop shopping" model has been an increase in referrals for other available services. Each of the medical providers has become knowledgeable in existing social services and public health programs, and this has resulted in a more efficient use of available resources and increased convenience for patients.

According to the project director, much of the project's success can be attributed to soliciting community ideas and suggestions during the planning stage. Two universities conducted focus groups in the five communities concerning health care needs and perceptions toward mid-level practitioners. A community needs assessment survey also was mailed to 2,864 households and received a 52% response rate. Project staff feel that these initial efforts have resulted in strong community support and increased use of project services.

The Fulton County Health Department leads the project's consortium. The other members include two universities, two hospitals, two pharmacies, a physician clinic, a mental health agency, city council members, and the county cooperative extension service. The consortium provides valuable direction on promoting and marketing project activities.

The current level of services will continue after the outreach grant expires through the sharing of expenses between public health and medical service providers. Funding from other grant sources is also anticipated.

PROJECT **17**

SELF—SELF ESTEEM LIFTING FOR FAMILIES
Fayette County Health Department, Vandalia, Illinois

Contact:
Cara Kelly, Administrator

Fayette County Health Department
P.O. Box 340
509 West Edwards
Vandalia, IL 62471
(618) 283-1044; (618) 283-5038 fax
E-mail:
fchd@swetland.com

A constellation of volunteer programs, initiated under this grant and known as GEM (Volunteers Going the Extra Mile), recently won the Illinois Rural Health Association Exemplary Project award. It is also in the final round for the Governor's Home Town award, and its coordinator has won a five-county Senior Citizen's award for her contributions.

When the Fayette County Health Department, located in south central Illinois, originally planned SELF (Self Esteem Lifting for Families — its outreach counseling program for students, young adults, and the homebound elderly), they envisioned a professional counseling services component complemented by a small home visiting program. What the consortium never envisioned, however, was that this volunteer program would give rise to a half-dozen programs involving almost 200 volunteers and reaching more than 10,000 individuals.

The first GEM volunteer program, Home Visitors, now has a core of 35 adults who have spent over 5,000 hours with more then 200 homebound senior citizens. An off-shoot of this program, called Jr. GEMs, has been created for junior high school students to visit patients in nursing homes. As the tide of volunteerism spread throughout the county, additional programs evolved to include Hospice; Mothers Outreach to Mothers (MOMs); Partners in Reading, in which volunteers read to first, second, and third graders; and RNs en Route, in which retired registered nurses show health education videos to homebound patients.

The professional component of the project also has achieved great success, reaching thousands of residents. Lutheran Child and Family Services, an experienced social service agency, was subcontracted to provide counseling services for the project. As of May 1997, agency professional staff had provided counseling services to 406 students and 20 parents, 20 probationers/status offenders as an alternative to the court system, eight homebound senior citizens, and 26 pregnant women. They also had held summer day camps for 150 at-risk elementary children, presented classroom activities to improve self esteem to 2,000 students, and supervised nearly 100 teens in support groups.

Project staff feel that both the professional and volunteer components of this program would work well in other rural settings. The volunteer component could be started with minimal dollars, even less than $1,000, according to the project administer, provided a good volunteer coordinator is found. This person must know how to make volunteers feel important and appreciated,

SELF—SELF ESTEEM LIFTING FOR FAMILIES

and how to match volunteers with compatible recipients. Unhappy volunteers don't stay volunteers for long. Funds are needed for name tags, coffees, postage, newsletters, and small tokens of appreciation for volunteers.

The GEM program was started by a part-time paid volunteer coordinator who recruited eight volunteers from an existing group. This core group talked enthusiastically to their peers in churches and organizations and then the coordinator recruited volunteers by making formal presentations. Many others also volunteered as a result of strong and positive media coverage.

To highlight a few of these programs, the Partners in Reading program assigns adults and older students to read to a child once a week during the noon hour. Within 12 months, four schools were participating. As of September, 1997, the program had expanded to three school districts and involved nearly 100 trained volunteers. Information has not yet been gathered on the effects of the program on academic achievement, but teachers and principles have noted remarkable improvement in the children, including greater self-confidence and social skills, heightened interest in school, and increased enjoyment of books and reading.

The MOMs program was initiated because the Health Department no longer had funds to make routine home visits to every newborn. The program used trained outreach mothers to visit new mothers, taking coupons, a small gift (donated by merchants), and written information about available health services. The volunteers assess the home situation and the relationship between mother and infant. Frequently an ongoing relationship is established, which offers emotional support, guidance, and friendship, and helps to reduce the stress of parenting. Follow-up visits are made by Health Department staff as necessary. As of May, 1997, the program's eight trained outreach mothers had visited over 80 new mothers, assisting the Health Department in their goal of assuring services to every newborn.

The project has trained 32 hospice volunteers to assist dying patients and their families. Also, a new GEM program, started in late 1997, involves 35 high school students trained to tutor elementary students.

One significant lesson learned by the project is that when one agency is providing services for another, the lines of authority and avenues for conflict resolution must be clearly defined. For

example, one obstacle that arose around the school program was a conflict as to who supervised the project counselors: the Lutheran Child and Family Services, or the schools. The problem was resolved with a meeting between all interested parties that clarified the counselors' role and responsibilities. There were no problems during the third year.

The project's consortium is led by the Fayette County Health Department. Other members include the Fayette County Hospital, the probation department, and four school districts. Lutheran Child and Family Services was not an official consortium member, although it provided direct services, participated in all meetings, and was primarily responsible for the success of the program.

Most of the project's activities will continue after the grant period. The schools plan to hire 3-5 counselors. The Health Department will support the Hospice program and counseling for homebound senior citizens. Lutheran Child and Family Services will support the Volunteer Coordinator with discretionary funds. The agency has also received a grant from the Illinois Department of Children and Family Services to continue its counseling for unwed mothers and the MOMs program.

PROJECT 18

TASC/MISA PROJECT
The Fellowship House,
Anna, Illinois

Contacts:
Greg Lence, MISA,
Program Coordinator

Mickey Finch, MS,
Chief Executive Officer

Norma Spurlock, RN, BSN,
Executive Director

The Fellowship House
P.O. Box 682
800 North Main Street
Anna, IL 62906
(618) 833-4484

Many mentally ill, substance-abusing individuals in rural southern Illinois face barriers to obtaining treatment. Traditionally, mental health and substance abuse treatment programs have very different philosophies and treatment styles. This has precluded access for the dually diagnosed client. There has also been a lack of coordination of mental health and substance abuse treatment, resulting in clients being referred back and forth between the two systems with neither system alone being successful in treating these clients.

For more than 10 years, The Fellowship House of Anna, Illinois, has offered special case management services for dually diagnosed individuals in a program called MISA (Mentally Ill/Substance Abuse). In this outreach project, it has extended its services to a new set of clients, the dually diagnosed individual involved in the criminal justice system.

The overall goal of the project is to assist these individuals in stabilizing their lives in their communities, decrease their recurring involvement with the criminal justice system, and increase their use of mental health and substance abuse treatment services. The project provides intensive case management services including screening and assessment, service planning, linkage to treatment and other social services, monitoring, support for clients and their families, transportation, and criminal justice system activities. Because of the stigma related to criminality, mental illness, and/or substance abuse, case managers also strongly advocate for their clients in the areas of housing, employment, education, and vocational training. They also assist mental health and substance abuse agencies in overcoming their reluctance to treating these difficult clients.

The project has succeeded through a strong collaboration between treatment providers, case managers, and the court system. The Fellowship House, a residential and outpatient substance abuse treatment program, and TASC (Treatment Alternatives for Special Clients) are the lead agencies in the consortium. The Fellowship House works closely with the agencies that provide mental health or substance abuse treatment services to clients in the program. It also provides alcohol/drug treatment services to clients referred to the program. The Southern Illinois TASC office works closely with members of the court system — including judges, probation officers, state's attorneys, and public defenders — to generate referrals and monitor the progress of each client.

PROJECT 18

TASC/MISA PROJECT

The project's consortium also includes the court systems in each of the eight participating counties, which generate the initial referrals and provide motivation for clients to comply with the program; seven community mental health or substance abuse treatment centers, which serve as primary service providers for clients; and the Clyde Choate Mental Health Developmental Center, which provides inpatient mental health treatment.

The program has been so effective in working with the targeted population that the criminal justice systems from two additional counties asked and were allowed to join the consortium. Treatment providers from these counties also joined the project.

As of May 1997, the project had provided full case management services to 54 dually diagnosed individuals referred by the courts. It was surprising to project staff that at intake 38% had not had prior substance abuse treatment and 55% had not received prior mental health services. Data suggest that participants in the program have reduced legal problems, less difficulty in daily living, and have made progress in substance abuse treatment programs.

Although The Fellowship House has worked with dually diagnosed clients for many years before this outreach project, the clients referred by the criminal justice system have been more challenging because their mental health diagnoses often differ from individuals not involved in the court system. Referrals from the court system typically have personality disorders, whereas referrals from outside the court system usually have thought or mood disorders. Clients with personality disorders have an overall tendency to be less compliant and exhibit more problem behaviors than thought or mood disordered clients, and this has created greater challenges for providers in developing services.

Much of this project's success can be attributed to the close working relationship that TASC and The Fellowship House have enjoyed for more than 10 years. The project's community mental health programs have also been part of a consortium with The Fellowship House since 1990. "This history of cooperation and mutual planning has been invaluable in the development of this project," writes the project director. "If that is not already in place, much training is necessary in getting mental health services and alcohol/drug services to think in terms of treating mental illness and alcohol/drug dependence simultaneously."

TASC/MISA PROJECT

Lack of public transportation continues to pose one of the project's greatest challenges. Most of the clients do not have a driver's license and have difficulty finding rides. Transporting clients is the case manager's most time-consuming activity, after support and monitoring. The Fellowship House recently hired a driver to provide this service full-time. The large geographic area also creates significant travel times to and from seeing clients, which cuts into the time that case managers can spend providing direct services.

Procuring medication for physical and mental health problems is also a problem, particularly when the client has not been diagnosed or been in treatment before. It takes time to obtain a medical card or social security disability, often requiring documentation over an extended period.

As the TASC/MISA outreach project draws to a close, clients who are still in need of case management services will be absorbed into the existing Mentally Ill/Substance Abuse program at The Fellowship House. The agency will continue to work with TASC in receiving referrals from the court system, and will work with community service providers to make referrals and monitor client activity and progress. The agency plans to keep 10 slots in its case management program open for dually diagnosed clients referred by the courts. Two case managers and one new part-time case manager will absorb the referrals.

This outreach project was conceived out of the belief that persons suffering from mental illness can benefit greatly from physical and emotional wellness programs. Club Health was developed to provide personal wellness programs in a friendly and supportive atmosphere to all those suffering from chronic mental illness in Jasper County, Iowa.

Progress Industries, the project's lead agency, donated space for the Club Health facility. The facility houses an exercise room equipped with treadmills, stationary bikes, stair steppers, and a multi-station weightlifting machine. A weight loss support group meets weekly and a walking group meets daily. Frequent trips are also made to the local YMCA (also a consortium member) for exercise purposes. A library at the facility offers literature on a wide range of health-related subjects. A paid coordinator oversees the outreach program.

As of May 1997, the project had helped 114 individuals start a personal wellness program. It has also sponsored 45 other wellness activities and one support group. These numbers are not as high as the project had hoped. In retrospect, staff feel that while Club Health may have responded to a genuine need for physical wellness, the perception of this need in the target population was low and not adequately addressed. "Although wellness is a goal that we have for persons with mental illness, it is not necessarily high on their list of priorities," writes the program director. "This is a program that we wanted for them, perhaps more than they wanted themselves." If this type of program is to succeed elsewhere, it must put strong emphasis on personal contact and motivating members on a continual basis.

Other problems faced by this project were a lack of adequate space and a lack of transportation to the club for many participants. The project was also unable to secure reimbursement for its services.

The project's consortium was led by Progress Industries, a non-profit agency that provides service and support to individuals with disabilities. Other consortium members included the Newton YMCA, the Jasper County Department of Human Services, and several other agencies that provide educational and treatment services for the mentally ill. Consortium members provided referrals and consultation; however, cooperation between agencies was not optimal, according to the program director, and this also hindered the project's success.

JASPER COUNTY WELLNESS PROGRAM FOR PERSONS WITH MENTAL ILLNESS

Progress Industries,
Newton, Iowa

Contacts:
Katherine Trotter,
Grant Director
(515) 791-0652

Carol Swift
(515) 791-2831

Progress Industries
1017 East 7th Street North
Newton, IA 50208

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PROJECT **19**

JASPER COUNTY WELLNESS PROGRAM FOR PERSONS WITH

Club Health will not continue once the outreach grant expires. However, it is possible that the local YMCA may hire a staff person to assist all persons with disabilities, not just mental illness, in developing and maintaining personal wellness programs.

Mortality due to trauma in rural America is very high. First responders to rural trauma need the best training available, yet they often have only basic skills. Similarly, emergency room care in rural primary care hospitals does not approach the level found in most secondary or tertiary trauma centers. To remedy this problem, Northwest Iowa Community College developed this outreach project to coordinate, unify, and improve the training of all medical personnel in the region who treat trauma patients, in both the pre-hospital and hospital arenas.

The five-county region served by the project contains eight independently-operated rural, hospitals (all fewer than 50 beds in size); and 36 emergency medical services (EMS) systems, all of which are municipally sponsored and staffed by volunteers. Before this outreach project, no network existed among these agencies or the physicians who serve them.

During the three-year grant period, 154 emergency medical technicians (EMTs) have taken a Pre-Hospital Trauma Life Support course and 12 EMTs have received scholarships and a monthly stipend to complete their paramedic training. In the hospital arena, the Trauma Nurse Core Course has been given to 144 registered nurses (RNs) who staff emergency departments. Six qualified RNs have received funding to take the Emergency Nurses Association Certification Exam. In addition, at least one physician from each of the eight area hospitals has attended Advanced Trauma Life Support Training.

Programs have been provided to participants in a variety of ways. The Trauma Nurse Core Course was delivered under contract with a larger hospital who had instructors on staff. These instructors came to Northwest Iowa Community College to provide training. Under the grant, the College also contracted with the University of Iowa to provide instructors for the Pre-Hospital Trauma Life Support course for EMS personnel. During the second year, the community college trained its own instructors to teach the course. By the third year, eleven instructors had been trained.

Physicians taking the Advanced Trauma Life Support Training were given a choice of locations to attend class because training was not available locally. EMTs who received the paramedic scholarships were also given a choice of location. Access to these courses improved during the second year, when a state-wide paramedic training program was started over the Iowa Communications Network (based in Iowa City at the University

NORTHWEST IOWA TRAUMA TRAINING CONSORTIUM
Northwest Iowa Community College, Sheldon, Iowa

Contact:
Ruth J. Hobson, RN,
Health Occupations Coordinator/Grant Project Director

Northwest Iowa Community College
603 West Park Street
Sheldon, IA 51201
(712) 342-5061 or
(800) 352-4907
(712) 324-4136 fax
E-mail:
rhobson@nwicc.cc.ia.us

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NORTHWEST IOWA TRAUMA TRAINING CONSORTIUM

of Iowa). This means of delivery was a great asset to the students, who could take the course locally at Northwest Iowa Community College as it was broadcast over the network.

Joining the Northwest Iowa Community College in the project's original consortium were representatives from each of the eight area hospitals and 36 local EMS systems. From this body, an executive committee was chosen, consisting of four hospital personnel, four medical services personnel, and the project director from the community college. This executive committee became the mainstay of the project, overseeing all major changes or decisions, including determining the recipients of the paramedic scholarships. (The third year awards were difficult as there were 10 applicants for only four awards.)

As is the case in many rural areas, there had been a tremendous need for unified and improved trauma training in this region. Project staff feel that this project could be replicated in most rural areas, particularly if that area is served by a community college or other educational entity that could coordinate the efforts. Northwest Iowa Community College is more than willing to share the operational details with anyone wishing to replicate the project. Evaluations of the training programs reveal a high level of satisfaction among the participants.

The fruits of this outreach project come at a time when the state of Iowa is establishing a state-wide system for trauma care. Each hospital will apply for certification in a certain level of trauma care according to the types of services it can deliver. The system will also mandate trauma training for health professionals. The hospitals in the region feel that they are already one step ahead because of the trauma training provided under the grant during the last three years.

The Northwest Iowa Trauma Training Consortium will be able to continue its activities after federal support is completed. Nurse and EMT instructors trained under the grant will continue to provide instruction to new employees. The college will offer the Trauma Nurse Core Course and Pre-Hospital Trauma Life Support for new hires on a tuition-for-services basis.

FINNEY COUNTY PRIMARY CARE PROJECT

United Methodist Western Kansas Mexican American Ministries,
Garden City, Kansas

Contact:
Penny Schwab,
Executive Director

United Methodist
Western Kansas
Mexican American
Ministries
Box 766, 224 North Taylor
Garden City, KS 67846
(316) 275-1766
(316) 275-4729
E-mail: mam@gcnet.com

The meat production/processing and agriculture industries of southwest Kansas attract large numbers of uninsured and undocumented residents. Many of these individuals experience financial, language, or cultural barriers in accessing primary care. The Finney County Primary Care Project was designed to provide bilingual, culturally appropriate health care services to residents of Finney and outlying counties. It specifically targets those who are uninsured, indigent, recipients of Medicaid, and/or have limited proficiency in English.

Three advanced registered nurse practitioners were recruited to provide services at a network of already existing health clinics run by United Methodist Western Kansas Mexican-American Ministries (MAM), the project's lead agency. Services include primary and preventive care; dental, nutrition, and social services; and mental health and substance abuse services. The project also has initiated several outreach and screening programs specifically geared to Hispanics.

As of August 1997, about 6,500 new clients had accessed primary and preventive care through the MAM clinics. The overwhelming majority — 88% — are women and children age 17 and under; 97% have incomes low enough for them to be eligible for food stamps and other social services. About 69% of the persons served are Hispanic; 23% Anglo; and 8% Asian, African American, or Native American. Eight thousand immunizations have also been administered through the grant.

One of the project's most notable contributions is that it has provided prenatal care for all Finney County women who do not have access to private providers. For the first time, the rate of low birth weight infants in Finney County has dropped below the state average. In the absence of a controlled study, however, the cause-effect relationship between the project and this outcome cannot be proven.

MAM has a long history of providing health and social services throughout southwest Kansas. Joining MAM in the consortium are St. Catherine Hospital, owned by the Dominican Sisters; and Area Mental Health, a regional mental health agency. This outreach project represents the first time these agencies have worked together on a formal basis to coordinate service delivery.

In addition to the grant activities, the improved working relationships forged through the consortium have led to other

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FINNEY COUNTY PRIMARY CARE PROJECT

beneficial programs for this population. St. Catherine Hospital and MAM have teamed up with the Kansas Department of Health and Environment to operate the Southwest Kansas Diabetes Control Project and the Kansas Breast and Cervical Cancer Initiative. The Diabetes Control program has conducted almost 2,000 patient contacts, involving either one-on-one education or a visit to a physician or mid-level provider. The Breast and Cervical Cancer program has provided 764 patient contacts.

Most project activities will continue after the grant period, although the lack of grant funding will reduce the number of people receiving primary care services. The consortium is working on increasing Medicaid revenues, and MAM is seeking federal funds for a Section 330 Community Health Center. A Primary Care Coalition, consisting of the outreach grant consortium and the Finney County Health Department, will continue to work toward project goals and monitor progress.

PROJECT **22**

NORTHWEST KANSAS RURAL STROKE PROJECT
Gove County Medical Center,
Quinter, Kansas

Contacts:
Susan George, ARNP-C,
Project Director

Paul Davis,
Administrator

Gove County
Medical Center
5th and Garfield
Quinter, KS 67754
(785) 754-3341

The Northwest Kansas Rural Stroke Project was designed to lower the incidence of stroke in Northwest Kansas and to improve the treatment and treatment outcomes for individuals who suffer strokes. While these goals may be similar to those of other stroke prevention projects, it is believed that this project is unique in its method of bringing stroke risk screening to the elderly. The project provides public education and assessment clinics at 54 senior centers and aggregate meal sites supervised by the Northwest Kansas Area Agency on Aging, a consortium member.

A nurse practitioner visits each of the senior centers once every three months to educate elders on stroke prevention, risk factors, warning signs, and the importance of quick response to symptoms. She provides physical exams for many of the elders to identify high risk factors, makes referrals if necessary, and follows up on behaviors to ensure that modifications have been made. A network of senior volunteers, organized by the Area Agency on Aging, facilitates the clinics and posts notices in newspapers, cafes, and church bulletins urging everyone over age 65 to participate. The average age of participants is 83.5 years.

About 28,500 elderly individuals live in this 18-county region, constituting 27% of the total population. The 20,000-square-mile service area is sparsely populated with fewer than six persons per square mile. For this reason, it is strategically advantageous to target centers where seniors gather for news, companionship, and daily meals, and to incorporate direct health care and education services into existing senior center activities.

Through communication with professionals in the American Heart Association, National Stroke Association, U.S. Public Health Service, and other organizations, project staff have concluded that this project is unique in the country, and even in the world. "We believe that this project is on the cutting edge of the delivery of stroke prevention techniques," writes the project director. "Through clinical evaluation, we know that this delivery method of prevention intervention works. The single-disease focus increases acceptance in the target population that transcends general health-related topics, yet it opens the way for discussion of basic lifestyle modification."

As of May 1997, 6,473 elders had participated in stroke risk assessment educational sessions, and 2,289 had taken the opportunity for a physical examination by a nurse practitioner. Of those examined, 619 were assessed at high risk because of

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NORTHWEST KANSAS RURAL STROKE PROJECT

factors such as hypertension, heart rhythm discrepancies, carotid bruits, lifestyle, or medical noncompliance. Physician intervention for these individuals includes recommendations for lifestyle changes, exercise, lowering blood pressure, and treatment for heart rhythm discrepancy.

A scientific statement issued by the American Heart Association suggests that these measures could prevent between 60 and 100 strokes in this population. Given that the average stroke costs $30,000 for acute treatment and up to $70,000 for long-term care, it is possible that the dollar savings to the health care system in Northwest Kansas alone could range from $1.7 million to $6.93 million. This does not include the costs in anguish and pain to stroke survivors and their families.

Stroke survivor rehabilitation clinics sponsored by the project and caregiver support groups have provided individual and family assistance to 275 individuals. Information programs to civic and church groups and a monthly health column in a senior newspaper have also increased public awareness of stroke as a health problem.

The project's educational outreach also extends to physicians and other health care providers. Together with Kansas University Medical Center's Center on Aging, their Kansas City Stroke Study, and their outreach professional education center, the project has brought continuing education on stroke symptoms, treatment, and prevention to the rural setting using telemedicine, in-house presentations in small hospitals, and face-to-face consultations. As of May 1997, 21 physicians and 452 nurse and allied health professionals had participated in these continuing education opportunities.

Because the ultimate goal of this project is to reduce the incidence of stroke, the project is keeping scrupulous records to assist a longitudinal study on preventive stroke intervention. The project has enlisted the state peer review organization to analyze this project's effect on long-term stroke admission rates, and Kansas University Medical Center's Center on Aging to analyze data on risk factor outcomes. These studies are expected to extend at least two years beyond the grant period.

The Gove County Medical Center, a 21-bed rural hospital, serves as the project's lead agency. The consortium consists of Northwest Kansas Area Agency on Aging; the Northwest Kansas Area Health Education Center (AHEC), which is the University

NORTHWEST KANSAS RURAL STROKE PROJECT

of Kansas Medical Center's continuing education center; and a group of medical and allied health professionals working through volunteer channels of the American Heart Association.

In addition to the consortium, the project has established collaborative relationships with other individuals and organizations, including experts from the area's major medical centers, researchers conducting stroke-specific scientific studies, and organizations such as the American Heart Association and National Stroke Association. County health departments have also been brought in to increase local commitment and to ensure continuation of efforts after the program ends. The involvement of local professionals as well as senior volunteers in each community has been vital to the project's success.

The Northwest Kansas Rural Stroke Project will continue two years after the grant expires through funding from the United Methodist Health Ministry Foundation and matching local funds. Prevention clinics will be offered in churches, and it is expected that one to two thousand new elders will be examined in these new sites. At the end of the Foundation funding, the project intends to convert to a more decentralized model funded by each county. By this time, it is expected that protocols and guidelines will be in place so that a county health department, parish, hospital, or physician's office can provide the screenings.

The Child and Family Outreach Project was implemented in Whitley County, Kentucky, to ensure that every pregnant women and child under age four receive appropriate health care and social services. The child poverty level in this mountainous county is 42%. Half of all adults lack a high school education, and unemployment is high. Domestic violence, abuse, and neglect threaten the health of the population, as do teenage pregnancy and high infant mortality rates.

Lack of transportation is probably the most significant barrier that keeps residents from accessing needed health care. Secondary and tertiary roads are often narrow and substandard, and there is no public transportation. To address this problem, the Whitley County Health Department implemented a home visiting program for pregnant women and families with young children. An outreach team works together to assess needs; assure access to and use of prenatal, preventive, and screening health care programs; and provide in-home education.

The project's outreach team consists of five paraprofessional outreach workers, a registered nurse, and two social workers. The outreach workers are mothers from the community who serve as peer mentors. Their qualifications include cultural sensitivity, knowledge of community resources, and communication skills. Before starting the home visits, they go through an intensive two-week training program, taught by registered nurses, in which they learn prenatal and baby care. Social workers and representatives from a nearby domestic violence shelter provide instruction on the warning signs of domestic violence and how to handle these situations. The outreach workers have also become certified in the federal Parents As Teachers program, and participate in ongoing weekly in-service trainings.

The outreach worker is typically the first team member to visit the home and enroll the family in the project. If needed, the social worker or registered nurse conducts a follow-up visit. Once enrolled, each family receives at least one monthly visit, and high-risk families or families with on-going needs are visited weekly.

The objective of the outreach team is to consider the needs of the entire family. Referrals are provided as needed to services including health care, housing (HUD), education, immunizations, parenting skills courses, transportation, financial assistance, and the WIC nutrition program.

CHILD AND FAMILY OUTREACH PROJECT
Whitley County Health Department,
Williamsburg, Kentucky

Contacts:
Peggy Henderson,
Project Coordinator

C. Gail Timperio,
Director of
Administrative Services

Whitley County
Health Department
P.O. Box 147
114 North Second Street
Williamsburg, KY
40769-0147
(606) 549-3380 ext.17

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CHILD AND FAMILY OUTREACH PROJECT

As of May 1997, more than 350 families, including nearly 700 children, had participated in the home visiting program. Two hundred and fifty families and 426 children are currently enrolled. One hundred percent of the women participating in the program have received prenatal care and more than 95% have received care during the first trimester. The project has referred 225 women and children to WIC and 332 children to the health department for immunizations and well-child exams. All of the children with developmental delays or disabilities have been referred to appropriate agencies for screening.

The outreach staff has also joined efforts with the City and County Resources Centers, the local Housing Authority, the local Boards of Education and the Even Start Program to conduct monthly community parenting workshops. Participation has far surpassed expectations, with an average attendance of 90 adults and 50 preschool children. The outreach staff also conducts weekly classes. These parenting classes are the only classes in the Tri-County area that meet the requirements of court-mandated and Department of Social Services parenting skills classes.

Leading the project's consortium is the Whitley County Health Department. Other members are the Whitley County Communities for Children (a community-based, non-profit group) and the Cumberland River Clinic (a federally qualified health care center). Referrals to the project come from the health department, local physicians and clinics, other programs for pregnant women, and by word-of-mouth. Many of the families involved in the project recommend the program to other pregnant women or families.

Lack of transportation continues to be the most significant challenge faced by this project. This has made it difficult for many families, especially high-risk pregnant women or families with infants, to maintain the continuity and quality of their care. To address this problem, project staff have offered gas vouchers to neighbors or friends who can drive the client, or linked the client to other families who have transportation. On a limited basis, they have even provided transportation in their own vehicles. Another problem has been the lack of easily accessible health care for high-risk pregnancies. Women without medical cards or private health insurance must often travel to Lexington or Knoxville to find a provider (a three-to six-hour round trip) and this creates an additional expense and transportation burden.

CHILD AND FAMILY OUTREACH PROJECT

The project encountered some resistance from physicians during its implementation. Much time needed to be invested in building relationships with local physicians and explaining that the project was not in competition with them or a duplication of existing health care services. "As soon as they realized that we were reinforcing what they were telling patients, and helping patients access health care, however we were overrun with referrals from physicians," writes the project coordinator.

One of the most significant lessons learned by the outreach staff has been that they can't "fix" everything. "For instance," writes the project coordinator, "if a family lives in very poor conditions, but is content with that environment, we cannot try to force the family into 'better' conditions because that's what we want for them. The family should tell us what they need help with — not the other way around."

Project staff feel that the home visit model is especially effective in rural areas. It allows for a valuable rapport between provider and consumer, and delivers needed services to the home, thereby overcoming the transportation barrier. The use of paraprofessional outreach workers has also been highly effective in reaching a large number of families that otherwise might have fallen through the cracks of conventional social services.

After the grant period, the project hopes to continue its activities by converting many of its activities into billable services. Public health nursing (including some home visiting services) and limited social work services that are billable will be reimbursed under the Medicaid program. Services provided by the community health outreach workers may continue on a limited basis if consortium members can pool resources and support this effort. The project is seeking support for Medicaid billable paraprofessional home visiting services. It is also seeking additional funding from other sources such as public health tax dollars and private foundations.

The impetus for this outreach project was an unmet need for health care services in rural western Kentucky. This area, known as the Green River District, begins at the Ohio River and extends westward into the coal region. Many residents here lack adequate health care due to unavailable services, inaccessibility to services, lack of transportation, and financial constraints.

Three new primary care clinics were established under this grant, serving three counties. The clinics provide a range of primary care services encompassing both outpatient diagnostic care and medical treatment. Everyone is provided services, regardless of their ability to pay. Services provided include preventive health care, on-site laboratory testing, dispensation of commonly used drugs and biologicals, and referrals for specialized care. The project has also sponsored a blood drive, health fair, and screenings for prostate cancer.

As of May 1997, the three clinics had provided primary care (in one or more visits) to 686 individuals. Because the clinics did not start providing care until ten months into the grant period, this number reflects just two years of operation.

The reason for this delay, and by far the greatest obstacle encountered by the project, was the difficulty in recruiting qualified medical personnel. Initially, the project sought to hire an advanced registered nurse practitioner to provide primary health care. However, extensive recruiting efforts, beginning before and extending into the grant period, failed to obtain a person with these credentials. The project then tried to recruit a physician assistant, and although one was found, this person did not have the requisite two years experience under a physician as required by Kentucky law. Fortunately, the health department had a long-standing relationship with a physician who agreed to step into this role temporarily. It is with this team of professionals that the three clinics finally opened their doors to the public ten months after the grant was awarded. (Eventually, the project did recruit a advanced registered nurse practitioner and a full-time physician.)

The Green River District Health Department provides services at the three clinic sites, conducts all outreach activities, and shares managerial and administrative responsibilities with the McLean County Fiscal Court, the project's lead agency. The Ohio County Fiscal Court and the Ohio County Board of Health provide space for the third clinic site. The final consortium

MCLEAN COUNTY RURAL HEALTH OUTREACH PROGRAM
McLean County
Fiscal Court,
Calhoun, Kentucky

Contacts:
Deborah S. Fillman
Green River District
Health Department
1600 Breckenridge Street
Owensboro, KY 42302
(502) 686-7747 ext.1331
(502) 926-9862 fax

Larry Whitaker,
Judge Executive
McLean County
Fiscal Court
Box 127
Calhoun, KY 42327

MCLEAN COUNTY RURAL HEALTH OUTREACH PROGRAM

member, Ohio County Hospital, left the consortium after it declined to fulfill its initial commitment to the project.

The Green River District Health Department will attempt to continue providing services at the clinics after the outreach grant expires. It is unlikely, however, that the clinics will be self-sustaining, even with reimbursement from Medicaid, Medicare, and third-party payors. Project administrators are applying for additional support in the form of grants and other funding sources.

KENTUCKY

RURAL OUTREACH PROGRAM FOR ELEMENTARY STUDENTS (ROPES)
Gateway District Health Department, Owingsville, Kentucky

Contacts:
Jean Smith, RN,
School Health
Unit Coordinator

James R. Ratliff, Jr.,
Public Health Director

Gateway District
Health Department
P.O. Box 555
Gudgell Avenue
Owingsville, KY 40360
(606) 674-6396

The Rural Outreach Program for Elementary Students (ROPES) project in rural eastern Kentucky provides health and social services to school children in five elementary schools, three in Morgan County, and two in Menifee County. About 35% of the population in this area lives below poverty level, and access to medical care is limited due to a shortage of physicians, lack of transportation, and cultural beliefs. The school-based health program provides services to children and their families, and has obtained a high level of support from the schools, parents, and the community.

A registered nurse at each school provides child health services including physical and developmental assessments, immunizations, routine school health screenings (e.g., vision, hearing, scoliosis), assessment of acute illness or injury, first aid, and referrals to other community health care providers. The nurses also administer medications, conduct basic laboratory tests, teach health education in the classroom, and provide home visits to children and families.

In addition, the project offers nursing services to family members. These include blood pressure screenings, immunizations, monitoring of chronic health conditions (such as diabetes), and health education. The project has also contracted with Pathways, Inc., a community mental health agency, to provide on-site mental health services.

In another component of the project, an on-site social worker provides classroom presentations on such topics as conflict resolution, decision-making skills, suicide prevention, and self-esteem building. They also help link children and their families with community resources to meet identified needs.

One of the most positive outcomes of this project is that more parents are collaborating with the health care team and school personnel regarding the health and educational needs of their children. The project director attributes this to several important factors. First, extended hours at the school-based clinics have provided working parents with better access to services. Second, all services are provided free of charge to students and their families instead of being based on household income or ability to pay. "This approach removed the stigma of the clinics serving only 'poor students' and promoted more active participation of parents in their child's health care," writes the project's

RURAL OUTREACH PROGRAM FOR ELEMENTARY STUDENTS (ROPES)

director. Parents often express appreciation to the staff for the convenience and quality of health services provided to their children.

As of May 1997, project nurses had provided 450 child preventive health exams; 893 childhood immunizations; 21,694 services for illness, injury, and school health screenings; 1,060 referrals for health care, vision, and hearing services; and 75 nutrition counseling sessions. Adult services included 227 immunizations and 1,212 other units of service including health care, referrals, and health education. On-site social workers had provided 2,062 units of service.

The schools are already noting positive results from the project, and this has prompted at least seven other area schools to request similar elementary health nursing services from the Gateway District Health Department. (Funding is being sought to support these programs.) Both the Morgan and Menifee school districts have reported decreased rates of absenteeism due to the school-based health services. Screenings and referrals for vision and hearing problems have resulted in higher academic achievement for the students, and immunization rates have improved.

The consortium initially consisted of the Gateway District Health Department (the project's lead agency), Morgan and Menifee County School Systems, St. Claire Medical Center, and Morgan County Appalachian Regional Hospital. Since its inception, nine other groups have joined the consortium, including local universities, other hospitals, school systems, social service agencies, and a mental health agency. Now called the Gateway Region Interagency Delivery System (GRIDS), the new consortium's goals are to improve the health, social well being, and educational outcomes of the region's children and families.

One of the most significant problems encountered by the project was locating adequate space for the clinics in the already overcrowded schools. Innovative solutions included using an existing dental unit, remodeling a workroom for clerks and social workers, renovating a locker room, and, when no space could be found within the building, renovating a mobile home to house the health unit.

All ROPES services will continue after the outreach grant expires. Menifee and Morgan County Schools have contracted with the Gateway District Health Department for the continuation of nursing services. The health department plans to support the clerk and social worker positions through Medicaid and reim-

bursement for well-child exams. A University of Kentucky pediatrician has applied to a private foundation for funds to expand the ROPES program. If funding is received, services will include diagnosis and treatment by a nurse practitioner, expanded dental services, assistance to families in paying for prescriptions, and a full-time mental health worker.

RURAL OUTREACH PROGRAM FOR ELEMENTARY STUDENTS (ROPES)

PROJECT **26**

SOUTH CAMERON MEMORIAL HOSPITAL RURAL HEALTH OUTREACH GRANT — TELEMEDICINE PROJECT

South Cameron Memorial Hospital, Cameron, Louisiana

Contacts:
Cathy L. Denison-Wicke, PhD, Director of Special Projects and Telemedicine
(318) 542-5250 or
(318) 494-2861

Jenny Broussard, Telemedicine Technical Coordinator
(318) 542-5285

South Cameron Memorial Hospital
5360 West Creole Highway
Cameron, LA 70631

Telemed, the South Cameron Memorial Hospital's telemedicine project, is a two-way interactive video telecommunications system used to link rural underserved patients with urban medical facilities. The outreach project has established seven Telemed sites throughout southwest Louisiana — five in rural hospitals, one in a facility for the developmentally disabled, and one in a mobile telemedicine clinic (a 36-foot Airstream recreational vehicle that travels to rural sites for health screenings and telemedicine encounters).

Project staff hope that Telemed will provide a number of benefits to rural residents, including access to additional medical expertise, reduced expenditures of time and money for traveling to distant medical centers, reduced hospital stays because of better preventive care and faster diagnosis, and greater success in recruiting physicians to their communities. In addition to its videoconferencing capabilities, the system also offers store-and-forward technology for patient images and computer information.

The Telemed system has allowed the project to connect rural patients with distant providers for such services as routine diagnosis, specialty consults, medical follow up, emergency triage, medication checks, management of acute or chronic illness, rehabilitation therapy, patient education, preventive medicine, and telepsychiatry. All patient consults are provided by Louisiana State University (LSU) Medical Center in New Orleans, a consortium member.

As of May 1997, 411 patients had received primary care and health education through the telemedicine project, far exceeding the project's original goals. Approximately 40% of these encounters have been for routine diagnostic care, 34% for medical follow up, 10% for special diagnostic testing, and 6% for patient education. The project has also established a Telemed site with the Southwest Louisiana Developmental Center, a rural, state facility for the developmentally disabled. The center is the first telepsychiatry site in the state.

Ninety-five percent of the patients who have used Telemed report they are satisfied, as have most of the physicians and other practitioners. Some physicians, however, are reluctant to provide consultations through telemedicine because their services are not reimbursable. Other physicians, particularly older ones, resist incorporating new technology into their practice. The project has developed a physician awareness marketing program to

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PROJECT 26

SOUTH CAMERON MEMORIAL HOSPITAL RURAL HEALTH OUTREACH GRANT — TELEMEDICINE PROJECT

address some of these concerns. The state also is considering legislation that would make telemedicine reimbursable.

The project has used the Telemed system to provide continuing education for health professionals; supervise medical and health care students; and provide preventive and wellness programs for the community. All programming is provided by the LSU Medical Center. As of May 1997, the project had provided 467 educational programs for 1,538 participants. The consortium also uses the system for administrative meetings, grant consortium meetings, program development conferences, demonstrations, and business and industry programs.

The project's consortium consists of the South Cameron Memorial Hospital (a rural hospital and the project's lead agency), two other rural hospitals, one charity hospital, the LSU Medical Center/University Hospital, the Louisiana Health Care Authority (the governing body for the state's charity hospital system), a non-profit regional tertiary hospital, a non-profit screening clinic, and the Southwest Louisiana Developmental Center.

The most significant problem faced by this project was a political power struggle during the first year between the charity hospital system, the rural hospitals, and the LSU Medical School. The consortium provided an ideal environment within which to resolve these conflicts, build more supportive working relationships, and create a successful telemedicine program. Currently, all the entities are working well together.

Most activities started under the outreach grant will continue after the grant period. Operational expenses will be covered by revenue brought in from Medicaid reimbursement and program fees. Telemed's conferencing and continuing education programs will start charging fees in June 1997. The project is also applying for other federal and state grants to expand and enhance its outreach services, as well as seeking funds from foundations and local sources. New Telemed sites will be expected to cover their own expenses.

PROJECT **27**

PEER & COMMUNITY SUPPORT FOR PEOPLE WITH MENTAL ILLNESS IN RURAL AREAS (PEERNET)

Medical Care Development, Inc., Augusta, Maine

Contacts:
John A. LaCasse, President

Todd Remage-Healey, Director of Mental Health Projects
Medical Care Development, Inc.
11 Parkwood Drive
Augusta, ME 04330
(207) 622-7566
E-mail:
tsremage@mcd.org

PeerNET is a network of rural support groups developed and operated by and for people with mental health problems. Many rural residents struggle daily with unemployment, poverty, and a lack of support systems. Others struggle with depression and isolation. Unfortunately, many do not seek the support they need because of the perceived stigma attached to mental illness, or because no mental health services are available. The purpose of PeerNET is to help people learn to help themselves and each other, build natural support systems, and create their own sense of community and belonging.

The foundation of the project is a network of peer support groups, developed and facilitated by a staff of three full-time and three part-time people. Most of the staff are graduates of a state-funded program that trains people with mental illness in the areas of group facilitation and community development.

Seven groups now meet in two rural sites: Kezar Falls, located in York County near the New Hampshire border, and Piscataquis County, an undeveloped, less populated county to the north. The groups meet weekly and include an average of seven to nine people per group. A broad spectrum of mental health diagnoses is represented in the groups, including depression, bi-polar disorder, post-traumatic stress disorder, and severe anxiety.

The focus of PeerNET is to help group members focus on recovery and quality of life rather than on diagnosis, medication, or hopelessness. Discussions center on self-esteem building, communication skills, handling anger and conflict, improving relationships, making friends, and building support systems. Participants are encouraged to keep the discussion in the "here and now," rather than delving into issues that should be explored with a professional therapist. The purpose is mutual support, not therapy.

In addition to the discussion groups, the project provides a continuum of other support services that include outreach intervention, crisis prevention, and community education. Outreach interventions are provided either over the phone or in person when a group member needs extra support. The staff provide about 24 of these interventions per week .

About once a week, a group member experiences an episode of feeling "in crisis" because of a relapse of illness or the stress of daily life. A PeerNET staff, often accompanied by another

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PEER & COMMUNITY SUPPORT FOR PEOPLE WITH MENTAL ILLNESS IN RURAL AREAS (PEERNET)

group member, helps this person assess his or her options and decide whether emergency mental health care is needed. Historically, many of these "crises" would have ended up in the emergency room of a local hospital. "But what we have found," writes the project director, "is that quickly having a low-level responder listen and give empathy is enough to help the person in crisis weather the storm and feel safe."

A standard quality of life survey, administered upon entry into the support group and then after six months of participation, indicates that participants feel very strongly that their situation and skills have improved. The most dramatic improvements are seen in self-esteem, handling crises, access to crisis support, and managing one's illness.

The project's lead agency is Medical Care Development, Inc., a health care research and development company with a long history of developing collaborative, community-based health programs for underserved rural Mainers. Other consortium members are the Sacopee Valley Health Center, a Federally Qualified Rural Health Center located in Kezar Falls; and the Alliance for the Mentally Ill of Maine, a statewide advocacy and education organization for families coping with mental illness.

The Sacopee Valley Health Center serves as a strong local anchor for the project and provides space for one of the support groups. "Without the health center the project would have struggled to gain acceptance in the region," writes the project director. "Its long standing presence in the community has helped attenuate the stigma of mental illness and counteract the reluctance of residents to get involved in the support groups."

Some interesting problems have arisen during the course of the project. Early on, staff had to be reined in when they began working nearly around the clock providing extra support to group members after hours and on weekends, even in their homes. Their dedication was praised, but they needed to be encouraged to take care of themselves and not impede the development of the group by providing too much support. On the flip side, some group members became overly attached to a particular group facilitator, and there was some concern that this would deter them from also forming relationships with one another. To remedy this situation, the project is experimenting with rotating group facilitators and emphasizing the importance of learning skills in addition to receiving support.

PEER & COMMUNITY SUPPORT FOR PEOPLE WITH MENTAL ILLNESS IN RURAL AREAS (PEERNET)

By far the greatest challenge is overcoming the stigma associated with mental illness. "All of our efforts have done little to change the communities' fear and misunderstanding of mental illness," writes the project director. It is clear that there are large numbers of people who could benefit from a community-wide support system, yet the project has to continually work to attract new members to the groups. "Ideally," he writes, "mental illness should enjoy the same acceptance as substance abuse. However we are far from that ideal, and that makes the challenge of PeerNET that much greater."

Funding from the Maine Department of Mental Health will allow the PeerNET program to continue after the outreach grant expires. The department had been funding the lead agency's community support training program, the catalyst for PeerNET, when PeerNET's outreach grant was received. It is expected that the department will support this new program when the demonstration grant ends.

PROJECT **28**

RURAL HEALTH OUTREACH GRANT

Bethel Family Health Center, Bethel, Maine

Contact:
Linda Ray,
Acting Executive Director

Bethel Family Health Center
P.O. Box 977
Bethel, ME 04217
(207) 824-2193

The initial goal of this project was to provide community-based services for substance abuse and mental illness in and around the rural town of Bethel, Maine. The service area has a population of about 6,250, characterized as mainly blue collar, low-wage workers in the tourism and lumber industries. Nearly 47% live below the federal poverty level, and roughly one in five adults do not have a high school diploma.

The proposed programs of this project were very ambitious in scope, and included a mental health alliance network for expanded mental health services, an adolescent addictions treatment program, and a home-based counseling program for children at risk. A number of unanticipated problems soon beset the project, however, and according to its acting executive director, its consortium lacked the working relationships and common goals necessary to weather the storm. Consequently, a number of proposed project activities were never realized.

The project's most fruitful activity, and the only one that will continue after the grant expires, has been the expansion of Stephens Memorial Hospital's substance abuse counseling and evaluation services into the town of Bethel, using office space provided by Bethel Family Health Center. The program, known as Gateway Recovery Services, has provided 3,206 substance abuse treatment encounters to 645 individuals as of May 1997.

Gateway counselors were invited to the regional high school to talk with students who had an interest in learning about chemical dependency. The counselors then formed groups to provide a safe place to ask questions. Twenty-eight support groups were formed, and an additional 68 individual students received counseling.

Other substance abuse prevention activities include an after school Safe Hangouts program, participation in job and wellness fairs, and working with community and school groups to promote healthy attitudes and habits. The project has facilitated a total of 1,674 prevention/education encounters.

As stated, the project was only minimally successful in meeting its goals, and a number of proposed projects were never realized for a variety of reasons. The Mental Health Alliance Network, for example, failed due to poor leadership and management, according to the acting executive director. The proposed mental health services were never made available. Two other proposed programs, the adolescent addictions treatment program and the home-based counseling program for children at risk, were never

RURAL HEALTH OUTREACH GRANT

implemented due to difficulties in recruiting and retaining qualified professionals. In addition, serious staff problems had a negative effect on the project.

The acting executive director writes that the initial scope of the project was too ambitious and the geographic distances between consortium members too large for the project to succeed. In evaluating what transpired, she recommends that participants in the planning stage of any project "emphasize the importance of laying out the groundwork, such as developing relationships and determining common goals, to promote the future effectiveness of the consortium."

The project's lead agency is the Bethel Family Health Center, a federally qualified health center. The consortium is completed by Stephens Memorial Hospital, a community hospital providing inpatient and specialized outpatient health care, and the Western Regional Council on Addictions, a substance abuse prevention program. Although the three entities joined the consortium with every intention of being mutually supportive, the course of events, and the uncertainty two of them faced in the changing health care scene, led them to disband after the grant period.

The only program component continuing after the grant period is the substance abuse counseling program (Gateway Recovery Services) provided by Stephens Memorial Hospital at the Bethel Family Health Center.

PROJECT **29**

AGRICULTURE CARE AND EDUCATION (ACE)
Garrett County Memorial Hospital, Oakland, Maryland

Contact:
Mikal R. McCartney, Program Specialist

Garrett County Memorial Hospital
251 North Fourth Street
Oakland, MD 21550
(301) 334-2155 ext.410

The Agriculture Care and Education (ACE) program was developed to reduce injuries and improve the health of the farming community in and around Garrett County, Maryland. Founded by the Garrett County Memorial Hospital, and joined by the county's health department and a statewide emergency medical services system, the project attributes its success to a community-based approach that has pulled together many different entities to work toward a common goal. "The ACE program has truly been a community partnership," writes the project director, "involving the extension service, farm bureaus, other agriculture organizations, fire and emergency response teams, local high school and college agriculture students and teachers, and other committed individuals and agencies."

The ACE program has three main components—health services, education, and response to agricultural emergencies. To increase the community's access to health services, outreach activities reach roughly 5,000 individuals yearly with health screenings and literature. Almost 500 individuals have received physician follow-up services.

The project's large educational component has extended to the medical profession as well as the general population. All primary care physicians in the area received information on agricultural risk factor reduction. Classes were offered to the public in cardiac risk factor reduction, tractor certification, and injury prevention. A progressive farm safety day camp was attended by 175 youths and 30 adults. Health and safety literature was widely disseminated at health screenings, county fairs, other community sites, and through other agencies and classes.

To improve the area's response to agricultural emergencies, the project offered 20 CPR classes and two Farmedic classes. Two EMS staff were also trained to teach the Farmedic course. Finally, the project purchased six automatic external defibrillators and two gas monitors for local fire departments.

From the beginning, the key to this project's success has been community involvement. Writes the project director, "Country wisdom, simply stated, advises that it is far better to do something with the community than to the community." To reach the large Amish population in the area, project staff met with the Amish Bishop and other community leaders to design the times and locations for activities that would encourage attendance. In many instances, this called for outreach staff to get up at 6:00

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AGRICULTURE CARE AND EDUCATION (ACE)

on snowy, Saturday mornings and travel to a rural church, fire department, or community center. Outreach activities and significant contacts were made at typical gathering places for the farm family — livestock sale barns, feed stores, equipment stores, restaurants, gas stations, grocery stores, churches, schools, 4-H clubs, and community centers. Transportation to the farm safety day camp was a barrier for the Amish youth, so a bus picked them up at the Amish school and returned them there at the end of the day.

Project staff feel that each of the three components of this project could be replicated individually or together in other rural areas. "The keys to success," writes the project director, "include assessing the needs of the target population and involving that population in creating solutions to meet those needs, finding linkages to share resources, and identifying each region's unique environment, agricultural methods, economic conditions, and cultural diversity."

Almost all project activities will continue after the outreach grant expires through the support of the consortium. Consortium members will also continue their advocacy for farm safety issues, and will seek additional grant funding to address other relevant farm safety issues when they are identified.

PROJECT **30**

The Connections for Care project in Wicomico County, Maryland seeks to bridge the gap in access to care for the region's minorities, uninsured, underinsured, and those with mental illness and addictions. This rural region, located between the Chesapeake Bay and the Atlantic Ocean, has a shortage of health care providers, and health indicators are generally poor as compared to other areas of the state.

To address these needs, the project established a primary care clinic in the town of Salisbury with the purpose of being accessible, affordable, and welcoming to its target population. Project staff visited the local emergency homeless shelter and other similar locations to provide information about the clinic and offer limited services such as flu shots.

Nurse practitioners provide the bulk of the clinical services, and are well received by patients. A number of physicians also volunteer on-site hours at the clinic, and provide after-hours call at no charge. These physicians serve on the project's consortium and were especially crucial to clinic operation during a major personnel turn-over at the end of the first grant year.

Other services provided by the clinic include patient education, limited assistance with prescription payment, and transportation services. A clinic case worker assists clients in accessing social services and drug company assistance programs. She also makes home visits to patients when such follow-up is indicated. Finally, the Wicomico County Health Department, a consortium member, provides on-site mental health counseling, which has greatly improved access to mental health care in the area.

As of May 1997, the clinic had seen about 1,200 patients in 5,000 visits. Roughly three-quarters of these individuals had no health insurance coverage, either through private insurers or government eligibility programs.

The clinic is housed in Joseph House Village, Inc., a non-profit agency that provides services to low-income and homeless persons. The agency also serves as the project's lead agency. Four other health care entities participate in the consortium: the Wicomico County Health Department; the Department of Nursing of Salisbury State University, a component of the University of Maryland system; Coastal Hospice, Inc., a non-profit agency; and the Maryland Department of Health and Mental Hygiene. Completing the consortium are local private physicians who volunteer their services.

CONNECTIONS FOR CARE
Joseph House Village, Inc.,
Salisbury, Maryland

Contact:
William Schaule,
Administrative Director

Joseph House Village, Inc.
P.O. Box 2517
Salisbury, MD
21802-2517
(410) 860-4806
(410) 742-1126 fax
E-mail:
wschaule@shore.intercom.net

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PROJECT 30

CONNECTIONS FOR CARE

One of the most difficult problems faced by the project has been a very high "no-show" rate for substance abuse and health education appointments. The project has had to discontinue its substance abuse services due to the problem, and health education services have been integrated into clinical appointments. There is a clear need for a "relatively aggressive consumer outreach and follow-up program," writes the project director. "Missed appointments and a lack of compliance with clinical recommendations need to be monitored regularly, but with sensitivity to the personal, economic, and cultural circumstances of clients."

The project has attracted some private financial support, including grants from foundations and the local United Way. But these funds, together with the limited direct patient and third-party fee collections, will not be sufficient in themselves to support the project after the outreach grant expires. Consequently, the project has established a formal collaborative arrangement with another non-profit, partially federally funded health care agency. The two agencies plan to work together to continue and expand services to the target population.

A consortium of public and private health care providers has established a clinic that provides comprehensive prenatal services for low income pregnant women in Dorchester County, Maryland. Before this outreach project, no consistent full-time prenatal care was available to this population. The county ranked as one of the highest in the state for infant mortality, low birth weight deliveries, adolescent pregnancies, and women receiving late or no prenatal care.

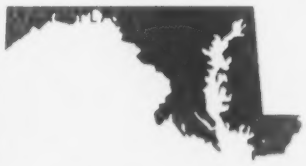
At the prenatal clinic, each new patient receives a physical examination, health education, nutrition counseling by a nutritionist, a WIC appointment, assessment for physical and emotional abuse, assessment by an addictions counselor, and an offer of HIV counseling. Services are provided by a part-time family practice physician with training in obstetrics. This physician also communicates with the obstetricians attending the delivery.

Each patient receives about 11 clinic visits and three home visits during her pregnancy. An estimated 160 prenatal patients received 1,790 clinic visits and 480 home visits during the clinic's first year.

In October 1994, the Fassett-Magee Community Health Center received a sizable State of Maryland Department of Housing and Community Development grant and a Public Health Service Community Health Center Planning Grant for the purchase and renovation of a facility to house the health center; the health department's nutrition program and intensive outpatient addictions program; and the Mid-Shore WIC nutrition program. This new facility opened in June 1996. In July of that year, the prenatal clinic began operations, allowing the consortium to achieve its goal of integrating health department services with primary care services, so that prenatal patients and their families receive continuity of care and long-term family practice coverage.

The "one-stop shopping" concept is particularly helpful for the low-income women and children who constitute the bulk of the facility's patients. The facility also is conveniently located within walking distance of many of its users. Low income and uninsured patients pay on a sliding fee scale according to their income, though all patients receive services regardless of their ability to pay. Project staff anticipate that about 4,500 patients will have been served by the end of 1998.

The non-profit Fassett-Magee Community Health Center serves as the project's lead agency. Other consortium members



PRENATAL OUTREACH PROJECT

Fassett-Magee Community Health Center, Cambridge, Maryland

Contact:
Linda L. Breland, Executive Director

Fassett-Magee Community Health Center
503 A. Muir Street
Cambridge, MD 21613
(410) 228-4045
(410) 221-6457 fax

PROJECT **31**

PRENATAL OUTREACH PROJECT

are the Dorchester County Health Department, which operates the prenatal clinic, and Dorchester General Hospital.

While the outreach grant provided the funds to equip the new facility's prenatal exam rooms, the project relied on a variety of outside resources to furnish the offices and exam rooms. One local business that was downsizing donated office furniture to the project; two retired physicians donated exam tables and equipment; and local banks and businesses donated computers.

One of the most difficult problems the program encountered was recruiting a physician to provide the prenatal services. After spending the first year in an unsuccessful search for an obstetrician, the project decided to search instead for a family practice physician with obstetric training. A physician with these qualifications was recruited in May 1996. The physician, a former National Health Service Corps Scholar, works part-time with the prenatal program and part-time in family practice at the community health center.

Another challenge came as a result of Maryland's rapid movement toward managed care. During the project's conceptual phase, it seemed logical to develop a small, stand-alone community health center. However, in May 1996, the Maryland Department of Health and Mental Hygiene submitted an application to the Health Care Financing Administration to institute mandatory managed care enrollment for Medicaid patients. "Small, community-based providers such as this one must position themselves in this new managed care environment or cease to exist," writes the project director.

Consequently, the community health center plans to unite with an existing federally-funded Section 330 Community Health Center to provide a system of care that is more competitive in the current and future marketplace. It is expected that this merger will improve the viability of the community health care system and enhance its capacity to provide primary health care, particularly for low-income and uninsured residents in the region. The two entities have applied to the Health Resources and Services Administration for a Community Health Center Expansion Grant to support this merger. Patient fees calculated on a sliding fee scale are also expected to provide some revenue.

PROJECT **32**

A volunteer network of more than 150 health care providers and advocates provide free primary care services to low-income, uninsured, and underinsured individuals living in Franklin County, Massachusetts. Although the Healthlinks project has only a handful of full-time clinical and outreach staff, its volunteer network and other innovative programs have significantly expanded the target population's access to affordable primary care.

The volunteers provide primary care at two free walk-in clinics in Greenfield and Buckland. In addition, the project's main office serves as a community focal point for patients and families needing information and linkage to health services. Clinical staff provide guidance, service coordination, advocacy, telephone assessments and referrals, and limited walk-in services. Because payment balances owed to physician offices are a major barrier to health care, clinical staff also negotiate with provider offices regarding balances owed, and, if necessary, assign patients to a new physician.

The project also operates a limited prescription assistance program for low-income individuals requiring non-chronic medications. The need, however, far exceeds Healthlinks' capacity to provide assistance. For chronic medications, a team of volunteers assists patients in applying for pharmaceutical companies' medication assistance programs.

In addition to free primary care, Healthlinks provides free diagnostic services to the target population through Franklin Medical Center, the project's lead agency. These services include blood tests and blood chemistry profiles, pap smears, CAT scans, and x-rays. A number of specialists also provide free or low-cost services to referred patients.

As of May 1997, volunteer physicians had provided primary and specialty care to 1,637 Healthlinks patients, many for multiple visits. The project also had provided prescription assistance for 177 individuals, and 768 diagnostic services free of charge.

The Healthlinks project has been fortunate to work in a community accustomed to forming partnerships to solve community problems. The consortium serves as an advisory board to the Franklin Medical Center, and has been actively involved in Healthlinks' development and evaluation. Other consortium members include Franklin Community Action Corp., which provides services to low-income families; Franklin County Home

HEALTHLINKS
Franklin Medical Center,
Greenfield, Massachusetts

Contact:
Patricia Kerrins,
Senior Manager for
Community Service

Franklin Medical Center
164 High Street
Greenfield, MA 01301
(413) 773-2070

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PROJECT **32**

HEALTHLINKS

Care Corp., the Area Agency on Aging; Services Net, which provides homeless shelter programs; Athol Memorial Hospital; the United Way; Franklin County Community Health Center; and Mohawk Regional High School. During the grant period, the consortium expanded to include a consumer representative, a volunteer physician, a volunteer nurse, and a primary care practice.

One of the greatest challenges faced by the project was the community's overwhelming need for dental services. Approximately 50% of Healthlinks' clients exhibited medical symptoms related to dental problems or were in need of dental services. The project recruited eight dentists and one oral surgeon to provide volunteer services, but the time donated does not nearly meet the need. The project has had to send patients far out of the area, as far as Boston, to receive free or sliding fee dental care.

Another challenge was obtaining the "buy-in" of the physician community into the volunteer program. Although community agencies and volunteer nurses recruited a large number of physicians for Healthlinks, the project director believes that even more could have been recruited had the effort been driven by physicians.

The Healthlinks project plans to integrate with the Franklin County Community Health Center when the outreach grant expires. The health center will provide free comprehensive primary and preventive care to the low-income uninsured, and will be reimbursed for this care through the state's free care fund. Services for the underinsured will be provided on a sliding fee basis.

The merger will retain several innovative Healthlinks programs. Specialty care providers will continue to provide free or low-cost services to the uninsured and underinsured referred by the health center. Franklin Medical Center and Athol Memorial Hospital will continue to provide free diagnostic services and will bill the free care fund when possible. Volunteer physicians will continue to provide primary care on an as needed, though much reduced, basis.

PROJECT **33**

A telecommunication system that merges voice, video, and data has improved access to health care and reduced isolation across Michigan's rural Upper Peninsula. Many communities in this sparsely populated region struggle to recruit and retain health care providers. Access to health care is limited due to long distances between communities, difficulty and expense of travel, a depressed economy, and a harsh climate. Already, the project has used the system to facilitate physician consultations, reduce turnaround time for diagnostic image readings, provide continuing education to rural physicians and allied health professionals, and support community health and wellness programs.

The outreach project has installed video conference and data transfer equipment, including teleradiology, at two rural health care clinics, two hospitals, and one non-health care facility. These sites are capable of sharing interactive video and images with other sites in the network.

As of May 1997, the telemedicine system had allowed 69 individuals, some from the region's smallest communities, to receive health care from distant practitioners. Mental health, surgical follow-ups, dermatology, and perinatal outreach have been the primary medical applications.

Continuing education for rural health professionals continues to be the system's most widely used application. The project broadcasts a weekly noon-hour continuing medical education program for physicians. Participation in an already successful inservice program for nurses surged in April 1997 when the state of Michigan began requiring continuing education for nursing relicensure. As of May 1997, 4,214 participants had attended the project's continuing education programs for physicians, and 4,180 had participated in the programs for allied health professionals (Some individuals attended more than one program).

The project has also used video conferencing to provide the public with a number of health education opportunities, including monthly physician lectures, childbirth preparation classes, and programs produced by the American Lung Association and the National Multiple Sclerosis Society. A cancer support group, with members from three Upper Peninsula communities, allows participants to learn about treatment, coping mechanisms, and to share experiences. More than 1,000 individuals have participated in these public education activities.

RURAL HEALTH OUTREACH PROGRAM

Marquette General Hospital, Marquette, Michigan

Contacts:
Sally Davis, MA,
Director of Education and Telemedicine

Danielle Waggoner, MPA,
Telemedicine Coordinator

Luanne Skrenes, RN, BSN,
Telemedicine Education Coordinator

Marquette General Hospital
429 West Magnetic Street
Marquette, MI 49855
(906) 225-3470
(906) 225-3037 fax
E-mail: uptn@voyager.net

PROJECT **33**

RURAL HEALTH OUTREACH PROGRAM

Finally, local community organizations, businesses, and public agencies have used the communications network to conduct teleconferences with distant offices. Also, local health departments also have used the technology to implement community health care projects.

Marquette General Hospital Regional Medical Center, the consortium's lead agency, provides the clinical consultations and educational programming for the project. Technical expertise is provided by Upper Great Lakes Educational Technologies, Inc., a non-profit consortium of schools and hospitals that assists in the development of telecommunications systems for distance learning programs. This entity is responsible for all equipment installation and upgrades, maintenance, and troubleshooting. Finally, the non-profit Upper Peninsula Emergency Medical Services (EMS) Corporation is responsible for developing and implementing continuing education programs for the region's 71 volunteer EMS groups.

Establishing consistent and reliable connections using the Integrated Services Digital Network (ISDN) has been an ongoing challenge for the project. Technical support staff have worked closely with Ameritech and the independent phone companies to rectify connection inadequacies. The project also has trained video conference system users in basic troubleshooting so that problems can be corrected in a timely manner.

Another challenge has been getting physicians to incorporate this technology into their routine practice. One drawback is the system's low bandwidth (128 - 384 Kbps), which has made the system unacceptable for clinical applications that require smooth motion handling. The system has proven adequate, however, for conferences, education, and clinical applications, such as psychiatry and perinatal outreach that do not require smooth motion handling.

Telemedicine services are expected to continue after the grant period, supported by the community groups and health care providers who benefit from network activities. Local sites will be responsible for equipment, upgrades, maintenance, and the continuation of transmission services. The project is also pursuing third-party reimbursement within the managed care environment.

PROJECT **34**

RURAL
PREVENTION
NETWORK
District Health
Department No. 2,
West Branch, Michigan

Contact:
Lynn Benjamin,
Community Prevention
Services Director

District Health
Department No. 2
630 Progress Street
West Branch, MI 48661
(517) 345-5020

A network of four rural health care entities is providing a variety of primary and preventive health care services intended to combat the high rates of chronic disease in northeastern Michigan. The four-county area is the most economically depressed in the state, and is characterized by low incomes, high poverty rates, consistent double-digit unemployment, and low educational attainment. Morbidity and mortality due to chronic disease far exceed state averages. For example, the rate of heart disease deaths among 45-64 year olds is 1.5 times the state rate. Compounding the problems of chronic disease and a high prevalence of risk factors is a shortage of health care providers, and a lack of organizations providing preventive services.

Project staff have developed partnerships with 52 local primary care physicians to create a comprehensive and coordinated system of preventive health services and education. These physicians refer patients to the project for assistance with lifestyle changes, and the project refers clients to the physicians for primary care. The project aims to complement, not compete with local primary care services.

To assist in patient education, the project has provided each physician with a TV/VCR unit and a video for patient viewing. The video contains five risk reduction programs. The end of each program provides a toll-free 800 information and referral number, and encourages viewers to work with their health care providers to reduce their risk for chronic disease.

The project also has developed and distributed an educational kit for providers called "Put Prevention Into Practice," which encourages physicians to incorporate preventive care into their practices. The kit addresses several barriers that have traditionally deterred physicians from offering preventive services. These include a lack of reimbursement for preventive services; lack of time, staff, and organizational structure; and patient and provider attitudes toward prevention services and counseling. "It is far easier to give out a pill for risk reduction purposes," writes the project director, referring to common blood pressure and cholesterol prescriptions, "than to provide education and counseling."

Other project services include smoking cessation and fitness/weight maintenance programs; nutrition counseling; diabetes counseling; CPR classes; worksite heart health assessments; and presentations to elementary school students. The project has used the media extensively to distribute preventive

PROJECT **34**

RURAL
PREVENTION
NETWORK

health messages, including public service announcements, newsletters, brochures, and weekly radio interviews. It also has implemented the toll-free information and referral telephone line, now averaging 300 calls per month, which directs callers to appropriate consortium members or other agencies. Project staff consists of four health educators, four part-time volunteer service coordinators, and an information and referral specialist.

As of May 1997, the project had served more than 36,000 individuals through direct services and its information and referral line. Direct services are provided for a nominal fee, with no one being turned away due to inability to pay. Follow-up surveys of clients suggest that about one-half have maintained risk reduction behaviors over time. It will take years, however, to assess the project's long-term impact on morbidity and mortality rates.

One of the project's most significant challenges was gaining the acceptance of physicians and getting them to refer patients to the project's health education and counseling services. Many physicians felt that patients were receiving adequate education through their nursing staffs and through pamphlets. "Sharing testimonials and risk factor results from previous consumers quickly turned their heads, however," writes the project director.

The project's lead agency is the District Health Department No. 2, which serves Alcona, Iosco, Ogemaw, and Oscoda Counties. Other members are the Alcona Health Center and Sterling Area Health Center (two rural health clinics), and the non-profit Tawas St. Joseph Hospital. These entities have "developed a strong commitment to solving service gaps and health problems together," writes the project director, and their collaboration will continue after the grant period.

The consortium is actively seeking funding through foundations and other state, local and federal funding sources. State funds have been acquired to support the worksite wellness program, and area service clubs and organizations will support the printing and reproduction of health education materials. The health district has identified tobacco use, alcohol use, and teenage pregnancy as its three priority health concerns. The project hopes to be the lead entity in charge of carrying out multiple strategies to address these health problems.

PROJECT 35

A consortium of health and social service providers has established a clinic that provides comprehensive services under one roof for pregnant and postpartum women. The clinic is open to women of all income levels in Crow Wing and Cass Counties, Minnesota. Both counties are rural and medically underserved, and are among the poorest in the state. Before this outreach project, the rate of women receiving no prenatal care, or accessing care in the third trimester of pregnancy, was 94% higher than the state average. Without prenatal care during the first trimester, a mother is three to six times more likely to have a premature or low birth weight baby, increasing the chances that the infant will not survive its first year of life.

The Good Beginnings Community Obstetrics Clinic provides comprehensive prenatal care — encompassing primary care, patient education, case management, and referrals — to pregnant and postpartum women and their infants. The clinic is open full-time and is located in Brainerd at St. Joseph's Medical Center, the project's lead agency. Three obstetricians and five family practitioners provide primary care services. They also provide family planning services before discharge from the hospital, and again at the postpartum visit.

Several public health and social service agencies also provide services at the clinic. Public health nurses from Crow Wing and Cass Counties Public Health Nursing Services provide prenatal education on-site, or at home visits for high-risk pregnant women when referred by a physician or clinic staff. They also provide postpartum home visits. WIC staff provide certifications and issue vouchers on-site, as well as provide nutrition and breastfeeding education. They also visit postpartum women in their hospital rooms to provide vouchers for the newborn infant. A certified lactation educator provides breastfeeding education.

The clinic coordinator is knowledgeable in all community services available to the pregnant woman and her family. She helps clients assess their own needs for services, provides information and referrals to services, helps schedule appointments, and follows up on referrals to see whether services were received. A representative from Crow Wing County Social Services helps pregnant women enroll for assistance or insurance programs.

The project also has established a satellite clinic at the Pine River Family Clinic approximately 40 miles north of Brainerd. Public health nurses are available there Wednesday afternoons.

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RURAL HEALTH OUTREACH DEMONSTRATION PROGRAM

St. Joseph's
Medical Center,
Brainerd, Minnesota

Contacts:
Jeanette Ruff, RNC,
Good Beginnings
Community Obstetrics
Clinic Coordinator

Ann Powers,
Office Manager,
St. Joseph's Home
Care — Fiscal Agent

St. Joseph's
Medical Center
523 North Third Street
Brainerd, MN 56401
(218) 828-7355
(218) 828-3126 fax

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PROJECT 35

RURAL HEALTH OUTREACH DEMONSTRATION PROGRAM

As of May 1997, clinic staff had provided prenatal work-ups to 1,418 patients, WIC certificates to 429 patients, nutrition education to 1,066 patients, and childbirth and breastfeeding classes to 849 patients. Public health nurses had conducted 3,782 one-on-one education sessions, and 2,237 home visits. During the grant period, there has been a decrease of nearly 3% in low birth weight infants, and the percentage of pregnant women receiving first trimester prenatal care has increased from 57% and 83%.

One of the project's greatest challenges has been the development of a standard flow sheet and a shared clinical record for each patient. Because of their different missions, each consortium member collects data in a different fashion. This makes compiling information on patients data a cumbersome and time-consuming process. A shared clinical record system would alleviate this problem in many instances, and would facilitate better coordination of patient care with less duplication of services. The consortium is currently developing such a system, which would allow viewing, editing, and standardized entry of data by all consortium members.

The Home Care Department of St. Joseph's Medical Center, a private, for-profit physician clinic, serves as the project's lead agency. Other members are Brainerd Medical Center; Cass County Public Health and WIC; Crow Wing County Community Health and WIC; Brainerd School District #181 Area Education Center; and Crow Wing County Social Services/Income Maintenance.

The project's success in improving patient education and access to health services has benefitted each agency in the consortium. The reduction in duplication and streamlining of services to pregnant women and their families will continue to enable all agencies to use their resources more efficiently and effectively.

This type of project would work well in other rural areas, provided that "all coalition members share a mutual vision and are willing to embrace each other's uniqueness," writes the clinic coordinator. "Coalition members coming from different focuses, e.g., for-profit, non-profit, and governmental, need to listen to and understand other members' organizational philosophies. This openness is essential in the successful development and continuance of a consortium."

The Good Beginnings Community Obstetrics Clinic is expected to continue after the grant period through the in-kind service contributions of consortium members. Third-party payment will continue for billable services provided to insured patients. The consortium is also pursuing other grant sources.

Mississippi has the highest teen pregnancy rate in the nation, and yet very few resources are available to combat this serious and growing problem. In 1994, 22% of all births in the state were to teens. Because teens are more likely to receive inadequate prenatal care, the rate of low birth weight babies and fetal deaths are much higher in this group than in other women. Project Prevention was designed to reduce teen pregnancies in three of Mississippi's neediest counties — Clay, Lowndes, and Noxubee counties. This outreach project encourages teens to wait to start a family, continue their education, and obtain the skills to live independently through vocational and job training.

Initial contact with the pregnant teen is made by the Health Department, a consortium member, which then refers the young woman to the project. Services offered to clients include counseling (individual, family, and group counseling), case management, nursing assessments, and referrals to vocational, job training, and GED programs. Project staff monitor clients closely to see that they keep scheduled medical appointments, and transportation is provided when necessary. The project's professional staff consists of one nurse, one therapist, five case managers, one coordinator, and one instructor from the Mississippi Cooperative Extension Service.

Education plays a crucial role in this project. The instructor from the extension service teaches clients about nutrition, parenting, and pregnancy prevention. This instructor also teaches an abstinence-based curriculum in the schools called "Values and Choices."

One of the project's most noticeable successes has been a reduced number of second births in its clients. Eleven percent of the project's clients had a repeat pregnancy, which is half the statewide rate of 22%. The rates of premature births, low birth weight babies and infant deaths also dropped below state averages. Clients in the case management program also experienced a decrease in emergency room use, attributable to improved prenatal care.

Although the project has achieved a successful drop in repeat pregnancies in its clients, it has been less successful in meeting its primary goal of preventing first pregnancies. Originally, staff hoped that the "Values and Choices" curriculum would include information on sex, pregnancy, and birth control. Yet most schools did not want this material presented out of concern that it would encourage students to have sex. Consequently, the curriculum was limited to the topics of self-esteem, honesty, equality, promise-keeping, respect, responsibility, self-control, and social justice.

PROJECT PREVENTION
Community Counseling Services,
Columbus, Mississippi

Contacts:
Karon Stanford,
Project Coordinator
(601) 328-3774

Joseph Scola,
Project Financial Coordinator
(601) 323-9261

Community Counseling Services
404 23rd Street North
Columbus, MS 39701

PROJECT 36

PROJECT PREVENTION

The project has identified three major barriers that continue to hinder its clients from pursuing educational and employment opportunities. These are a lack of quality, affordable child care, a lack of transportation, and a lack of real employment opportunities. The area served by the project has had historically high unemployment rates and menial employment opportunities. "The long-term solution must lie in linking the community to education, and education to meaningful employment," writes the project director. While the program has emphasized education, it is now seeking to improve its links to employment.

The project's consortium is led by Community Counseling Services, one of the largest mental health organizations in the state. The Health Department and the Mississippi Cooperative Extension Service complete the consortium. Much of the project's success is attributed to the excellent rapport between consortium members.

Some of the project services will continue after the outreach grant expires, but on a smaller scale. The Health Department will continue to refer at-risk or pregnant teens to the project, and project services will be reimbursed by Medicaid. State funding is being sought to cover the abstinence-based curriculum in the schools.

PROJECT 37

BUILDING HEALTHY PEOPLE IN HEALTHY FAMILIES

Bates County Health Center, Butler, Missouri

Contacts:
George Taylor, RN, BSN, Administrator, Project Director
Bates County Health Center
501 North Orange, P.O. Box 208
Butler, MO 64730
(816) 679-6108

Mary O'Connor, RN, PhD, Project Coordinator
St. Luke's Perinatal Center
44th and Wornall Road
Kansas City, MO 64111
(816) 932-6902

A consortium involving two county health departments, two school districts, and an urban hospital has had a measurable impact on the health of adolescents and their access to medical care in rural western Missouri. This comprehensive, school-based program involves health education and screening for all school-age children. It also provides obstetric case management for young pregnant women.

The project's stated goals reflect a holistic approach to health care: to improve the personal, social, physical, and emotional health services available to adolescents. In addition to teaching a broad health education curriculum developed by consortium members, project staff identify at-risk pregnancies in the school-age population and help these individuals access prenatal care. Staff hope that these efforts will reduce infant mortality and the incidence of low birth weight infants in this rural population, and health statistics gathered during the course of the project suggest positive improvements in these areas.

A nurse and certified teacher provide health education and screening in 11 public rural schools. The curriculum, developed for this project by the Vernon County Health Center, a rural county health department and consortium member, provides information and teaches skills to help students achieve mental and physical health. Every consortium member participated in the design, implementation, and evaluation of the curriculum.

The task of identifying medical and psychosocial risk factors in pregnant teens is the responsibility of the health departments in Bates and Vernon counties. Screenings have been improved by the purchase of a continuous feed fax machine, which is used to send neonatal non-stress tests to St. Luke's Perinatal Center in Kansas City, a tertiary care center and consortium member. This innovative use of telecommunications lines saves rural residents a long drive and reduces the time lost from school or work. It also allows for prompt referral of high-risk obstetric cases to St. Luke's when necessary.

The project has achieved its goals through a strong consortium that has enabled each member to provide more comprehensive services than it could have by itself. "By working together," writes the project director, "each member is more capable than any individual agency had been in the past." Bates County Health Center, a rural county health department, leads the consortium. Other members are the Vernon County Health Center, St. Luke's Perinatal Center and the Butler and Nevada school districts. St. Luke's has played a

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BUILDING HEALTHY PEOPLE IN HEALTHY FAMILIES

crucial role in project activities by serving as a resource for both education and case management.

As of May 1997, almost 2,000 students had been taught the health education curriculum, and roughly 1,750 have participated in the screening program. Twenty-three young women had been provided with preconception and/or prenatal referrals, case management, and access to neonatal non-stress tests.

The consortium is pleased with data from the Missouri Health Department showing significant drops in infant mortality, inadequate prenatal care, and low birth weight babies in the two counties. The statistics compare the 1992 rates (before the Healthy Families project began), and 1995 (after fifteen months of project activities). The incidence of low birth weight infants decreased from 14% to 4.4% in Bates County, and from 14% and 7.9% in Vernon County. The rate of inadequate care dropped from 19.4% to 9.1% in Bates County, and from 13% to 9.3% in Vernon County.

Given these positive trends, the consortium is committed to continuing the education, screening, and case management components of the project after federal funding expires. A grant from the state's Opening Doors program will fund the curriculum and screening components. Case management for at-risk pregnancies will now be covered by the Greater Kansas City Fetal Board, which is funded through the Spies Foundation and Patton Trust.

The consortium arrangement has been so successful that members have agreed to expand their collaboration to address the problems of tobacco use, alcohol use, and driving under the influence of alcohol. It also hopes to educate young people about career opportunities in the health care field.

PROJECT **38**

HOSPICE 2000: A COMMUNITY-BASED, RURAL, TEACHING HOSPICE FOR NORTHEAST MISSOURI

Kirksville College of Osteopathic Medicine, Kirksville, Missouri

Contacts:
Ron McCullough, Administrator
Hospice 2000
406 South Fourth
Kirksville, MO 63501
(816) 627-9711

Beverly Nichols, Project Coordinator
800 West Jefferson
Kirksville, MO 63501
(816) 626-2719

Hospice 2000, a newly established, non-profit hospice, has teamed up with the local college of osteopathic medicine and the Northeast Missouri Area Health Education Center to provide hospice services to a seven-county region in rural northeast Missouri. The hospice provides palliative care and extensive support services to terminally ill patients for whom curative intervention is no longer appropriate. It also provides grief/bereavement support to family members for up to one year after the death of a loved one. All services are provided regardless of age or ability to pay.

"Our consortium has been a vital component to the success of the program," writes the Hospice 2000 administrator. "Being associated with two established, well-respected local entities has assisted in the community's acceptance of the program." The Kirksville College of Osteopathic Medicine, a private, non-profit osteopathic medical school, serves as the project's lead agency. Faculty physicians refer terminally ill patients to Hospice 2000 and train the school's 550 students in hospice care. The Northeast Missouri Area Health Education Center, a non-profit corporation, provides education programs about hospice to health care students, health professionals, and the community.

There were no hospice services available in the region before the establishment of Hospice 2000. As of May 1997, the program had provided hospice care to 125 individuals, and grief/bereavement services to more than 800 family members and loved ones. Hospice 2000 has also been a vital resource for the larger community, offering grief/bereavement services to three schools who have lost a number of students, as well as to local factories and businesses. The project also facilitates a quarterly grief support group offered to hospice families and the entire community. Because of the outstanding services provided by Hospice 2000, two additional counties have invited the hospice to serve their areas, increasing the service area to nine counties.

One of the unique aspects of this project is its commitment to providing training in hospice care to health care students and community volunteers. Many of activities have been made possible by the project's association with the Kirksville College of Osteopathic Medicine. All first-year students in the general practice/family medicine curriculum now receive formal didactic training on hospice-related topics. The college also offers a clinical rotation in hospice care, and 76 students have participated. An additional 120 students have also participated in ride-along visits to hospice

PROJECT 38

HOSPICE 2000: A COMMUNITY-BASED, RURAL, TEACHING HOSPICE FOR NORTHEAST MISSOURI

patients and families. Finally, to encourage community participation, the hospice has provided training to more than 100 community volunteers.

In addition to educating health care students, the project actively works to inform the general population about hospice care. To date, project staff have presented more than 200 educational programs to various local civic, church, and education institutions, reaching more than 3,000 people. It has distributed more than 8,000 brochures and produced multiple newspaper and radio public service announcements. "You must always be visible to your public when offering a service that is unique and often misunderstood," writes the project coordinator. "Public speaking engagements are essential not only in the beginning, but throughout the life of the program if the hospice is to succeed."

Hospice 2000 is committed to providing the highest quality of service possible, and to do so it relies on feedback from quality assurance reviews and client surveys. "Feedback from the consumer is our greatest review," writes the project coordinator. "We ask physicians, patients, and families to assess the care we provide."

Hospice 2000 will continue to offer hospice care and grief/bereavement support with funding from other grants, Medicare/Medicaid hospice reimbursement, and private insurance. The project's educational programs for health care students and the community also will continue.

PROJECT **39**

MISSOURI VALLEY HEALTH SPAN CONSORTIUM
John Fitzgibbon Memorial Hospital, Inc.,
Marshall, Missouri

Contact:
Charlene McFadden, BSN, RN,
Project Director

John Fitzgibbon Memorial Hospital, Inc.
P.O. Box 250
Marshall, MO 65301
(816) 886-7431 ext.293

Concerned health professionals have established a handful of innovative preventive health programs for residents of west central Missouri, an area devastated by the 1993 flood. Before this outreach project, there was no formal coordination between any health and human service providers in Carroll, Chariton, and Saline Counties. The consortium formed under this outreach grant, known as Missouri Valley Health Span, is a network of community service providers committed to working together to identify unmet needs and find resources to meet those needs.

One of the first programs established by the consortium was a toll-free telephone number, known as The Care Connection, that serves as a one-stop source for information and referral. An information specialist answers questions about where to find such services as emergency food, housing, energy assistance, or transportation to distant medical care. Callers are then referred to the appropriate agency for services.

A second program, called Community Care Teams, organizes multiservice care teams for individuals, families, or communities with complex health and social service needs. A masters-level nurse and social worker serve as Community Care Coordinators for this program. Together with the referring agency, these staff members call together other community service providers who may be helpful because of their programs or expertise. This multiservice team, which includes the client, develops a coordinated service plan for the client. Team members sign a contract for tasks to be completed in the intervals between meetings, and they are held accountable to the team for completion of these tasks. The intent of this program is to bring together more people to problem solve and share responsibility for the client's needs.

The Community Care Coordinators also present a health education program called Take Care of Yourself. The curriculum teaches participants to become informed consumers of medical care and shows them how to handle selected medical problems at home.

The project's Heart to Heart program is a 24-hour emotional support phone line for people feeling isolated or distressed. The project provides a six-hour training program to community volunteers interested in staffing the phone lines. Callers needing further assistance are referred to the appropriate agency or The Care Connection.

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PROJECT 39

MISSOURI VALLEY HEALTH SPAN CONSORTIUM

Finally, special programs for youth include Mentoring Moms, which matches adolescent mothers with adult mentors, and an annual, intergenerational "Day in the Park."

As of May 1997, the Care Connection had assisted 489 individuals, and Heart to Heart had responded to 331 calls. More than 104 individuals had taken the medical self-care classes, four adolescents had been matched with adult mentors, and the intergenerational "Day in the Park" had attracted 2,000 participants. The Community Care Teams program, implemented in January 1997, had received 14 referrals in its first five months.

Turf battles, distrust, and fear of change have been the most significant barriers faced by this project. Some service providers were concerned that the project would compete for their clients or jobs. Project staff addressed these concerns with continuous communication and requests for feedback. "We seem to have the best success when we can make the benefits clear and realistic to those being asked to participate in our work," writes the project director.

Leading the project's consortium is the John Fitzgibbon Memorial Hospital, Inc., an acute care, skilled nursing facility. Other original consortium members include the Chariton County Health Department, the Missouri Valley Human Resources Community Action Agency, Marshall School District, and the District II Area Agency on Aging. The consortium has added other groups during the grant period, including the American Red Cross, the Carroll County Health Department, the Saline County Health Office (a nursing service), and local mayors.

All project activities are expected to continue after the outreach grant expires. Plans for the future include expansion into primary care services, which will generate revenue for the project through third-party reimbursement. The project also plans to market its services to managed care companies, conduct community fundraising campaigns for special projects, and pursue other grants and funding sources.

PROJECT **40**

This University of Montana project has adopted an unusual approach to outreach that has been received quite favorably in the rural community it serves. The project, which provides health information and screening programs to senior citizens in four western Montana counties, had been originally designed, as many programs of this type are, to send professionals and services from a large regional center out to rural communities. Yet, through trial and error, this project found that rural seniors respond more favorably to local health professionals than to speakers from out of town. With this revelation, the project shifted its focus toward developing local instructors for its health presentations.

Each month, a trained instructor provides a two-hour health information program at the senior citizen centers in 10 towns throughout the region, as well as at several sites in the city of Missoula. Some programs include screening services such as blood tests, hearing tests, and blood pressure measurements. Health programs are advertised through flyers and newspaper and radio ads.

Initially, the project hired health care workers from Missoula Community Medical Center, a consortium member, to do the presentations. Each health care worker would take one topic and present it to all the sites. This arrangement proved difficult to sustain, however, because some of the sites were up to 120 miles away, requiring up to six to seven hours total travel time in addition to the presentation time. This time commitment proved too large for most health professionals to take on in addition to their normal work load. The long distance also made it difficult for the presenters to develop any future association with the seniors they worked with for only two hours.

To resolve this problem, the project hired health professionals in each of the areas served to present the information, and provided them with the script, resources, and handout materials. This solution appears to have benefited everyone involved. Local health professionals have been pleased to have the resources and a venue within which to address the seniors in their area. More importantly, the seniors responded much more favorably to the local professional, someone with whom they could develop a tie for future needs. "The possibility of the speaker being accessible in the future was more important then their skill in presenting," notes the project director. The local presenters, even ones who were inexperienced and unpolished in their public speaking skills, were thanked much more warmly and received more questions than were the speakers who came in from out of town.

CHOIS (RURAL CONSORTIUM FOR HEALTH OUTREACH AND INFORMATION SCREENING)
The University
of Montana,
Missoula, Montana

Contacts:
Craig Ravesloot, PhD
(406) 243-2447

Colleen Murphy-
Southwick, PhD
(406) 243-2453

Montana University
Affiliated Rural
Institute on Disabilities
52 Corbin Hall
University of Montana
Missoula, MT 59812
(406) 243-2349 fax

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PROJECT 40

CHOIS (RURAL CONSORTIUM FOR HEALTH OUTREACH AND INFORMATION SCREENING)

Project staff hope an additional benefit of this approach is that rural residents who become acquainted with hospital staff through the educational programs may be more likely to seek health care within the community than travel to large metropolitan areas for their health care needs.

As of May 1997, the project had developed 26 health modules and presented this information in 286 programs. Almost 1,300 adults age 60 and over had attended one or more of these presentations. In addition, 76 health care professionals had been given resources and the support to work with senior citizens in their area.

One concern raised by the project director is that the seniors who participate in the programs are already self-motivated to seek information about preventive health. It is unclear whether this outreach program met the needs of those individuals who lacked this sort of self-directed motivation, and who may have needed this information the most.

The Montana University Affiliated Rural Institute on Disabilities served as the project's lead agency. Other members include the Missoula Community Medical Center (a not-for-profit hospital and rehabilitation center), the Agencies on Aging for Missoula and surrounding counties, and the University of Montana Departments of Psychology, Nursing, Pharmacy, and Social Work.

Members of the consortium and surrounding rural hospitals are considering establishing a health promotion program that draws upon the experience gained from this project. The major focus at this time, however, is on evaluating the project and the needs of the community it served.

A new Wellness Center in Livingston, Montana provides comprehensive preventive health services to the 16,000 residents of Park County. The center, which functions as an extension of Livingston Memorial Hospital, offers a multitude of health education classes, preventive screenings, and exercise programs targeting at-risk populations. One of the project's greatest strengths is that it remains flexible and dynamic, responding to the actual needs and available resources in the community. The community's support and participation, in return, has been overwhelming.

The project's first objective is to increase knowledge related to health and wellness. Public education classes cover a diverse range of topics, including healthy eating, stress management, cholesterol reduction, exercise, tobacco cessation, weight management, parenting, and numerous classes dealing with specific disease prevention issues. Local physicians also give free monthly lectures to the public on health-related issues. As of May 1997, more than 2,100 adults had participated in these health promotion classes.

Another educational offering is the project's Health Information Resource Center, complete with books, videos, and audiotapes available on loan to the community. Internet access has also been obtained recently, increasing the information available to the public and project staff.

A school facilitator employed by the project assists the school nurse in a number of screening programs, including vision, hearing, blood pressure, and scoliosis. She also assists in developing the school's wellness curriculum and teaches health education to grades K-5. One innovative teaching method has been to use older students as healthy role models to younger children through educational skits, videos, and radio ads. Screenings for middle school students emphasize muscle development and healthy eating rather than standard height and weight measurements. The project takes this approach so as not to encourage eating disorders, which often emerge in this age group.

The project also offers a number of screening programs to the general public for a minimal fee. Blood profiles focus on cholesterol and glucose levels and on kidney and liver function. The project also offers a blood test for prostate cancer, as well as a simple, self-exam kit for possible bowel cancer indicators. A Health Risk Assessment program helps individuals understand their personal levels of risk for disease and suggests changes they can consider to decrease their risk. As of May 1997, more than 3,400 adults had participated in the project's screening programs.

LIVINGSTEPS WELLNESS CENTER
Livingston Community Hospital Association,
Livingston, Montana

Contacts:
Nancy Dettori,
Program Director

Richard Brown,
Chief Executive Officer

Livingston Community
Hospital Association
504 South 13th Street
Livingston, MT 59047
(406) 222-8282

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LIVINGSTEPS WELLNESS CENTER

The project also offers on-site educational classes and screening programs to local businesses. Classes focus on worksite health and injury prevention, particularly back, wrist, head/neck and eye care. More than 160 individuals have participated to date.

The project's second objective is to increase fitness levels among participants. A new Fitness Center available to all ages offers a variety of fitness programs, including a medically supervised exercise program for persons with chronic illness. As of May 1997, 93 individuals had participated in this class, several of whom are in their 80s. Many of these clients have had their medications decreased as a result of regular exercise. An additional program has been implemented for seniors who do not require constant medical supervision. A release to participate is required from their physician.

As of May 1997, 715 individuals had joined the Fitness Center. All new members undergo a fitness evaluation by the Fitness Supervisor, who is also a certified Athletic Trainer and Physical Therapy Assistant. An individualized program is then developed to meet the goals and physical abilities of each member. The center also offers classes in yoga, low impact aerobics, and an aquatics program held at a local motel.

"We never anticipated the general community would so readily embrace the Fitness Center," writes the project director. "Many have said they are comfortable exercising in a supportive, non-threatening environment, often drawing inspiration from older, more debilitated clients who face the physical demands of daily living with incredible courage."

Livingston Memorial Hospital, the project's lead agency, provides the physical building and office equipment for the Wellness Center, as well as additional personnel salaries and a myriad of support services. Physicians at Park Clinic, a local medical clinic, serve as guest lecturers and review programs for medical accuracy. One physician also serves as the project's volunteer medical director. Other consortium members include Mental Health Services, which provides counselors and referrals when appropriate, and the Park County Health Department, which provides one registered nurse to the schools. This nurse works closely with the Wellness Center's school facilitator to provide screenings and health education programs for students.

During the next few years, the LivingSteps Wellness Center will make the transition to a fully self-sustaining department of

the hospital. Almost all project activities will continue, with the majority of revenue coming from Fitness Center memberships. Local businesses will co-sponsor the education classes. Fundraising efforts and small grants are also expected to generate support.

LIVINGSTEPS
WELLNESS
CENTER

Southwest Montana Telepsychiatry Network was designed to address the severe shortage of psychiatric services within a twelve-county region of Montana. The 28,500 square mile area has a ratio of only one psychiatrist per 30,000 residents. The network uses interactive video conferencing equipment to bring together psychiatrists, patients, and primary care providers located far from each other.

The project uses the network to provide direct mental health services to patients, including medication management, family and peer visitations, discharge plannings, court commitment hearings, and follow-up care. Psychiatrists, primary care physicians, and other mental health professionals also use the network for consultations and continuing education.

As of May 1997, the network had been used for 620 direct mental health consultations, 246 administrative conferences, 81 continuing education conferences, and 28 court hearings. The network uses "open architecture," meaning each site is capable of dialing out and directly interfacing with any compatible site in Montana, the U.S., or the world.

To date, the project has established five telepsychiatry sites in the service area. These are St. Peter's Hospital in Helena, the project's lead agency; AWARE Inc., a youth services agency in Anaconda, about 85 miles from Helena; and the Law and Justice Center in Bozeman, about 100 miles from Helena (facilitated by the Gallatin County Commissioners). The project's fourth site is the Montana Development Center, a state medical facility for the developmentally delayed in Boulder, about 35 miles from Helena. Its fifth site is Montana State Hospital, the state's only mental hospital, which is located in Warm Springs, about 60 miles from Helena. A sixth site will soon be operational at the state prison in Dear Lodge, about 60 miles away.

In all cases, the sites have been made available to all mental health patients and primary care providers in the community. Site facilitators have taken on this new role with enthusiasm in spite of the additional work in their already busy schedules.

The project's most successful activity has been the provision of continuing medical education. Through collaboration with the Montana Education Network of Video Conferencing and other hospital-based networks, the project has offered workshops to 25 sites throughout the state. Nurses, counselors, social workers, psychologists, teachers, and emergency medical personnel have all

SOUTHWEST MONTANA TELEPSYCHIATRY NETWORK

St. Peter's Hospital Foundation, Helena, Montana

Contacts:
Nancy A. Cobble, RN, MA, Project Director

Judy Baker, Telemedicine Coordinator

Southwest Montana Telepsychiatry Network
St. Peter's Hospital Foundation
2375 Broadway
Helena, MT 59601
(406) 447-2800

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SOUTHWEST MONTANA TELEPSYCHIATRY NETWORK

availed themselves of continuing education brought to their communities through this technology — education they would not have received without the network.

One of the most rewarding uses for this technology has been family and friend visits. A number of patients at the Montana State Hospital have been there for several years, and some families are unable to travel the long distance to Warm Springs to visit their loved ones. Having friends and families "visit" through video has motivated many patients to work harder toward their goal of being discharged from the hospital. One patient said, "I didn't believe anyone at home cared. After seeing and talking with them, I really want to go home." Another grateful patient hospitalized 500 miles from home wrote, "I haven't seen my son for almost three years and it was a great joy to be able to see him and speak with him at the same time."

Another innovative use of this technology is the provision of psychiatric occupational therapy sessions. A skilled potter in Helena has become involved in assisting in the therapy of the mentally ill. Occupational therapy sessions between this potter in Helena and patients in Warm Springs have resulted in an involved group of patients working with clay on a sustained basis with no loss interest.

One of the immediate challenges faced by the project is that many primary care providers within the twelve-county area were in the habit of referring psychiatric patients outside the region because psychiatric services were so sparse. "We have learned that development of a telepsychiatry network does not necessarily change existing referral patterns," writes the project director. In contrast, the project found that the mental health professionals were quite receptive to the telepsychiatry network, and a number of practitioners have adopted this technology to help treat patients at distant sites. For example, a psychiatric advanced practice registered nurse now uses network regularly for medication management of mentally impaired clients living in communities up to 150 miles away. A psychologist also now uses the technology to provide forensic evaluations for prisoners 500 miles away.

Only two of the original five consortium members remain involved in the project. These are St. Peter's Hospital, a non-profit community hospital and the project's lead agency, and the Montana State Department of Health and Human Services Division of Addictive and Mental Disorders. The other three

SOUTHWEST MONTANA TELEPSYCHIATRY NETWORK

original consortium members were unable to devote the personnel time and energy required to carry out their initial commitment to the project. They have been replaced by the rural agencies that use the equipment in the communities. These are the Gallatin County Commissioners in Bozeman, AWARE Inc., and the State Department of Corrections, in Lincoln.

The physical implementation and cost of the network has been one of the project's greatest obstacles. Before the initial grant application, the phone company US West estimated the cost for transmission for six sites at $32,000. Six months later, as the grant period begun, the project found the cost had been underestimated by $15,000 per site. Rather than modify the number of sites, the project chose to install roll-about, room-sized video conferencing equipment in a dial-up network using leased T-1 lines rather than a dedicated network. Using this less expensive option allowed the two additional sites — AWARE, Inc., and the State Department of Corrections — to join the network. In addition, new rules adopted by the Federal Communications Commission in 1997 significantly reduced the telephone rates, making the network even more affordable for rural sites.

The service area is so sparsely populated that the use of this technology solely for telepsychiatry will not sustain the network after the grant period. The project has expanded its use, therefore, into other telemedicine applications, such as providing follow-up care for surgical patients and tumor board review for cancer patients. A community needs assessment is underway to determine other potential uses for the network.

Each agency housing the equipment is committed to maintaining that equipment and continuing its use for telepsychiatry after the grant period. Reimbursement for services and fundraising is also expected to provide some revenue.

A mobile unit housing a full service family practice clinic is bringing much needed primary and preventive care services to four rural, medically underserved Nebraska counties. The mobile unit provides primary care services and referrals five days per week in four communities in Arthur, Deuel, Garden, and Keith counties. In addition, a close-knit consortium collaborates to provide extensive screenings, and health education and wellness programs to the general public.

A mid-level practitioner, registered nurse, and radiology technologist staff the mobile clinic. A wellness coordinator organizes and directs the health education and screening programs. Residents of all ages and financial means are eligible to receive services.

Services provided on the mobile clinic include treatment of minor and chronic illness, wellness exams, minor urgent medical care, follow-up treatment, mammography, and diagnostic radiology and laboratory work. Staff also provide patient health education and health risk appraisals combined with one-on-one counseling.

Through various consortium members, the project also has offered an extensive number of screenings and health education programs for the general public. These include blood pressure screenings, immunization clinics, car seat rental programs, health fairs, and educational classes in CPR, first aid, farm safety, nutrition, and exercise. The project also has developed and distributed a directory of human services agencies in the area.

As of May 1997, the project had provided primary care services to 2,117 patients on the mobile clinic. Almost 550 individuals had received health risk assessments and one-on-one education. The project's wellness activities also had attracted many participants, particularly its wellness sites (1190 users), blood pressure clinics (751 users), cholesterol clinic (128 users), immunization clinic (589 users), flu clinic (77 users), and exercise class (32 users).

The most significant challenges to the project have been equipment and mechanical issues related to the mobile unit. To prevent the occasional down periods from interrupting continuity of care, the project has worked with the communities to develop alternative sites and methods of care delivery when the mobile unit is not operational.

Leading the project's consortium is the non-profit Ogallala Community Hospital. Other members are the hospital-based Nebraska Home Health Care; Sandhills District Health

PRAIRIE
RURAL HEALTH
CONSORTIUM
Ogallala
Community Hospital,
Ogallala, Nebraska

Contacts:
Dena Klockman,
Finance Director

Linda Morris,
Administrator

Ogallala
Community Hospital
300 East 10th Street
Ogallala, NE 69153
(308) 284-4011

PROJECT 43

PRAIRIE RURAL HEALTH CONSORTIUM

Department; Support with Action Team, an inter-agency health and human services organization; and Volunteers of America, a Christian non-profit human service organization. The consortium arrangement has reduced duplication and helped coordinate the limited numbers of resources available in these rural communities, writes the project director.

The consortium is now pursuing other programs and initiatives to further meet the needs of its clients. These include state programs, school activities and planning groups, and county and civic programs.

After the grant period, the mobile clinic will continue to provide primary care services with some minor adjustments in scheduling and services to assure financial viability. The clinic will continue to charge for services and bill third-party payors for all covered services. Health education and wellness programs will also continue through in-kind support from consortium members and minimal charges to consumers.

PROJECT **44**

The high incidence of cancer in Thurston County, Nebraska was the impetus behind this outreach project. Located in a region of the Midwest known as the "Cancer Belt," the county's incidence and mortality rates for lung, colon, and rectal cancers exceeds state averages. In addition, the incidence of Non-Hodgkin's lymphoma is growing at an alarming rate. The project offers a variety of prevention education programs and free early detection screenings to county residents of all ages.

The project's most successful program is its summer Wellness Day Camp for primary school children. Its mission is to help children develop a sense of responsibility for their health and learn healthy behaviors. Local speakers from volunteer fire and rescue squads, hospitals, and schools present wellness activities during the two-day event. Participants learn nutrition while helping to prepare nutritious lunches. Service groups and local vendors donate food. Teen leaders help manage the children and provide a positive role model. The project has sponsored 13 Wellness Camps throughout the county during the grant period, with a total of 325 participants.

One of the project's most successful programming strategies has been to correlate local prevention/screening events with national calendar events. For example, during National Breast Cancer Awareness month each October, the project took educational materials to the schools to give to parents during parent teacher conferences. Smoking cessation classes were provided at the hospital and the local businesses during November, which is National Smoke Out month. The project offered cholesterol screening and a Heart Smart Program during February's Heart Healthy Month. In March, the project provided nutrition demonstrations in the schools and at Senior Centers to correspond with the national March on Nutrition Month.

The project also conducted a Farm Safety Day during late winter, when farmers were beginning to plan for spring planting. As part of the day, a local doctor conducted a skin cancer screening clinic, technicians took blood samples for early detection of prostate cancer, the Extension office provided soil and water specimen containers for free chemical analysis, and other agencies provided information about staying safe and healthy on the farm.

Other project activities have included a Wellness Fair for seniors; a Teen Wellness Class for Grades 7-12; and a "Lunch and Learn Prevention" education program for local businesses in conjunction with the Pender Chamber of Commerce and local service groups.

RURAL HEALTH OUTREACH GRANT PROGRAM

Pender Community Hospital, Pender, Nebraska

Contact:
Karen Hoag,
Project Coordinator

Pender
Community Hospital
Box 100, 603 Earl Street
Pender, NE 68047
(402) 385-2155

PROJECT **44**

RURAL HEALTH OUTREACH GRANT PROGRAM

The project also participated in several wellness fairs and screening programs on the Winnebago and Omaha reservations.

The project estimates that, as of May 1997, it had provided 4,200 individuals with prevention education and/or detection screenings. The project's most well-attended activities were the Wellness Day Camps (325 individuals), the Senior Center Wellness Program (480 participants in 16 locations), and the Elementary Nutrition Program (504 participants in six locations).

While programs targeted to youth and the elderly experienced high participation rates, the project struggled to reach the 25-55 age group. "No matter how programs were marketed, revised or presented, participation remained well below expected levels," writes the project coordinator. "Wellness education is a hard sell. It is advisable to target a specific audience and market the event extensively." Another difficulty has been the low response rates to client surveys used to evaluate project activities.

The project's consortium consists of Pender Community Hospital, the project's lead agency; Marian Health Center, an urban hospital located in Sioux City; Pender Community Schools; Siouxland Regional Cancer Center, the area's leading cancer treatment and education center; and the Nebraska Cooperative Extension in Thurston County, a university-based agricultural agency. Because some consortium members are located almost an hour apart, most consortium meetings are conducted through conference calls to save travel time.

Commitment to the consortium remains strong. Local businesses are being asked to sponsor the Wellness Day Camps, and campers will be charged a nominal fee. The Pender Community Hospital is considering continuing the education outreach program after the outreach grant expires. The periodic screening clinics will be offered at a reduced rate, and outreach services will be provided at cost. The project is also producing and marketing wellness videos to the community.

PROJECT **45**

PREVENTIVE HEALTH CARE IN FRONTIER NEVADA

Mount Grant
General Hospital,
Hawthorne, Nevada

Contacts:
Joyce V. Miller, CPA, CFO

Gregory J. Schumann,
Systems Manager

Mount Grant
General Hospital
First and A Streets
P.O. Box 1510
Hawthorne, NV 89415
(702) 945-2461

This outreach project provides much needed preventive care services in Mineral County, Nevada through two distinct programs — an adult day care center, and a health education and screening program. Mineral County is a designated frontier area, meaning that it has six or fewer persons per square mile and is more than 45 miles from the next level of health care services. In this case, Hawthorne, the county seat, is 130 miles from Reno and 310 miles from Las Vegas.

The project's certified adult day care center is located in a newly-built addition to the Mount Grant General Hospital's skilled nursing facility in Hawthorne. The center provides an essential service for families who need help in caring for an elderly family member but cannot afford the cost of a nursing home. Staff includes part-time registered nurses, certified nurse aides, and an activities director. A physician's assistant and a physician are also available when necessary. The program also provides transportation to and from the facility for its clients.

In its 21 months of operation, the facility has provided 293 patient days. The numbers of participants have been gradually increasing through promotional efforts and "word of mouth" advertising.

In its health education component, the project has sponsored a large number of health education/prevention seminars for the public over the grant period, attracting more than 2100 participants. Monthly mini health fairs have covered topics including nutrition, cardiovascular health, exercise, cancer, stress management, living wills, "The Price Tag of Sex," sports injuries, depression, Alzheimer's disease, and CPR. Educational programs presented at Mineral County High School and Hawthorne Junior High School have attracted particularly strong attendance, as have programs targeted to the elderly. The grant has also facilitated the restructuring of the school's health curriculum by its faculty to better meet student needs.

Generating attendance at these health education activities continues to be a challenge. "We've learned from experience that the best way to present preventive health information to younger people is in the classroom," writes the project director. "Another successful method of service delivery has been to combine a health seminar with a traditional recreation function. For instance, we used the annual AYSO youth soccer tournament in Hawthorne to promote the benefits of a drug, alcohol and tobacco free life."

Finally, the project has organized a number of screening and vaccination programs. Flu and pneumovax clinics offered in every

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PREVENTIVE HEALTH CARE IN FRONTIER NEVADA

community in the county have provided vaccines to more than 2,700 individuals. One thousand people have participated in the project's cholesterol study, and 353 students have received high school physicals.

Four organizations collaborate on this project — Mount Grant General Hospital, a public hospital and the project's lead agency; the Nevada Department of of Rural Health; the Mineral County senior center; and the Mineral County School District. The school district replaced the Walker River Tribal Health Clinic when it failed to participate in the consortium. The school district has proven to be an enthusiastic and active consortium member by providing access to the adolescent population and assisting in planning educational programs.

The project's adult day care center will continue after the grant period with revenue from Medicaid, commercial insurance, and self-pay sources. The project also plans to continue its most successful health prevention/education programs, supported through attendance fees.

A strong consortium of health and human service providers has developed a comprehensive network of health care services and educational programs for residents of Sullivan County, New Hampshire. The county is the second poorest in the state, and more than three-fifths of its residents have incomes low enough to qualify for social services assistance. The county also has the state's highest rates of teen pregnancy, low birth rate, and infant mortality.

One of the project's primary goals was to expand access to primary care services. This was accomplished at two agencies. First, Valley Regional Healthcare, Inc., transformed its Partners in Health Clinic into a comprehensive community health center, offering primary care and preventive services to residents at all income levels. (The clinic operated on a much smaller scale before the outreach project, was staffed by volunteer physicians, and served only indigent patients.) Services now include case management, nutrition education, pharmaceutical assistance, and screening services.

Second, Planned Parenthood of Northern New England expanded its existing family planning and prenatal services by hiring a nurse practitioner to provide primary care services. The agency also expanded the age range eligible for Well Child Services from 0-10 years to 0-25 years. As of May 1997, more than 3,000 individuals had accessed primary care through the Partners in Health Clinic and Planned Parenthood of Northern New England, and 175 had received Well Child Services.

A second major goal of the project was to provide school-based family support services and health education programs. Women's Supportive Services, a social service/domestic violence agency, provided an education curriculum coordinator to assist school personnel in developing a health curriculum that addresses "bully proofing", sexual harassment, self-esteem building, peer pressure, and dating violence. As of May 1997, more than 3,500 students had attended school-based education programs or health fairs where this curriculum was presented. The project also has offered a teen parenting group called Good Beginnings.

School-based case managers and a parent aide provide the project's family support services. Two case managers, each assigned to one school district, serve multi-problem and disenfranchised families. The Case Managers maintain a combined case load of 30-40 families. The project's parent aide works beyond the school setting, providing more direct and intensive intervention in the homes. The aide focuses on child and family dynamics, addressing such issues

SCHOOL AGE AND YOUNG ADULT HEALTHCARE PROJECT

Valley Regional Healthcare, Inc.,
Claremont,
New Hampshire

Contacts:
Laura Coleman,
Grant Administrator

Joan Churchill,
VP of Community Health

Valley Regional
Healthcare, Inc.
243 Elm Street
Claremont, NH 03743
(603) 542-1826

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SCHOOL AGE AND YOUNG ADULT HEALTHCARE PROJECT

as truancy, hygiene, self-esteem, and individualized needs. As of May 1997, more than 179 youth had received case management and parent aid services.

Services provided by the case managers and the parent aide have been enthusiastically welcomed by the schools and communities. Before this outreach project began, school guidance counselors found themselves inundated with multi-problem, dysfunctional families and had limited time and resources available to help them.

The impact and importance of the project was dramatically apparent at a May 1996 conference, of community leaders, when the assistant superintendent of the Sullivan County school system movingly and emotionally thanked the Project Coordinator and Case Managers for their efforts, which are producing positive results with at-risk students. The school system is seeking funding through the state Health Care Transition Fund to continue this much needed resource.

In 1996, the project administered a teen health assessment survey to 1,287 students in grades 6-12. Since then, the University of New Hampshire has conducted community forums with parents, youth, schools, youth-serving organizations, clergy, policy makers, and other agencies to develop strategies to address the most serious issues identified by the youth in the survey.

The project also has developed and distributed a comprehensive, county-wide resource directory that has received accolades from the community, as well as a first-place Lamplighter Award of Excellence from the New England Society of Health Care Communicators.

The consortium unites Valley Regional Healthcare, the project's lead agency; Planned Parenthood of Northern New England; the school system of Sullivan County; Women's Supportive Services; Connecticut Valley Home Care; Good Beginnings, a social service agency; the University of New Hampshire Cooperative Extension; and Partners in Caring, a consortium of 45 health and human service providers in Sullivan County formed in 1992.

"The intensive collaboration, communication, and relationships built between multiple agencies has been invaluable," writes the project coordinator. These relationships have lead to other ancillary activities and collaborations that have benefitted the community.

Funding from state and other sources will allow many project activities to continue after the grant period. The Partners in Health Clinic will continue to receive reimbursement for services, as well as support from the New Hampshire Department of Health and Human Services. The consortium is pursuing funding to maintain at least one case manager, the parent aide, and the education curriculum coordinator in the schools.

SCHOOL AGE AND YOUNG ADULT HEALTHCARE PROJECT

FARMWORKER ALCOHOL AND SUBSTANCE ABUSE PROJECT

Cornell University
Migrant Program,
Ithaca, New York

Contacts:
Denise Clark,
Assistant Director of
Sponsored Programs

Kay Embrey,
Director and Principal
Investigator

Cornell University
Migrant Program
College of Human Ecology
123 Day Hall
Ithaca, NY 14853-2801
(315) 483-4092

In New York State, as in other parts of the country, migrant farmworkers, resettled farmworkers, and other rural people of color face a multitude of barriers in accessing alcohol and substance abuse treatment services. A lack of bilingual/bicultural staff, nonexistent outreach services, and little or no understanding of the farmworkers' living conditions all contribute to creating barriers. Farmworkers also find it difficult to access services because they often lack phones and transportation. Some do not speak English and have cultural beliefs about drug and alcohol use that may be very different than the beliefs of those providing services.

The Farmworker Alcohol and Substance Abuse Project addresses these barriers. It visits labor camps and farmworker communities to provide outreach education, prevention services, and screenings or needs assessments. For clients in treatment the project provides counseling, employment and training services, and referrals for other health services. Case management services include transportation, translation, and assistance to the families of clients involved in treatment programs. Finally, the project conducts diversity training for staff and management in rural drug and alcohol treatment programs. The project serves Mexican, Caribbean, African American, Jamaican, Haitian, and Guatemalan farmworkers living in seven counties in western New York. All services are provided free of charge.

Through the outreach project, farmworkers have entered treatment and overcome addictions when they would have had no chance to do so without the project. As of May 1997, approximately 300 clients had undergone treatment. The project had provided 4,018 counseling and case management services, 3,159 education services, and 3,103 needs assessments (these numbers include multiple services to individual clients). Ninety-five percent of clients are male.

The most significant lesson learned through this project is that attitudes toward drug and alcohol use, as well as treatment outcomes, differ among cultural groups. "Healing the whole person must address the influence of race and ethnic identity upon the client," writes the project director. Treatment and support groups are formed based on the clients' cultural identity. Groups include African American men's groups, Latino women's groups, and Latino men's groups. The project cooperated with another agency to establish an African American women's group.

The project also has identified two integral parts of recovery for this population. First, it is important that clients reclaim their her-

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itage and take pride in their racial identity. Second, "traditional therapy and counseling must be augmented with an opportunity for clients to discuss their feelings of conflict and alienation resulting from the powerlessness and oppression they have experienced," writes the project director.

It also notes that clients are much more successful in inpatient versus outpatient treatment programs. "Trying to get to counseling appointments several times a week, interrupting work, and maintaining sobriety or staying clean while living in a camp or in housing where drug dealing is rampant is almost impossible for our clients," writes the project director. Unfortunately, most rural inpatient treatment services are not prepared to handle migrants, people of color, or monolingual clients, so clients have to be referred to urban centers for inpatient treatment.

An innovative component of this project has been its diversity training for staff and management in rural drug and alcohol treatment programs. "Most counselors and their supervisors are unaware of the way in which their assumptions and attitudes compromise their ability to provide effective services to people of color," writes the project director. "It takes concentrated effort to change this." The project has conducted workshops, inservice trainings and three-day retreats that examine the pervasive influence on staff of attitudes about race, ethnicity, and power. All agencies involved in the consortium have participated in the trainings, as have four other treatment agencies.

As of May 1997, the project had conducted 29 diversity training sessions with 662 participants. As a result, the quality of services has improved considerably at most sites, and some now have bilingual counselors. Resistance to change is very hard to overcome, however, and continues to affect clients in some sites.

The mobility of farmworkers continues to be one of the project's greatest challenges. Many farmworkers do not complete treatment because they leave the area to seek work or to avoid legal or other problems. This mobility is especially problematic when peer leaders of the self-help groups move away. Often the groups fold. The project has focused on training resettled workers as leaders, but there is still a need for group leaders in the labor camps.

Cornell University's Migrant Program serves as the project's lead agency. Other consortium members include two migrant health

FARMWORKER ALCOHOL AND SUBSTANCE ABUSE PROJECT

centers; the Catholic Family Center-Restart, a drug treatment program; Finger Lakes Alcohol Counseling and Referral Agency; and Rural Opportunities, Inc., an employment, training and housing agency. These agencies have never worked together in the past, and the consortium arrangement has greatly improved the communication between them. Clients also have benefitted through improved client services and referrals.

The project was discussed last year at the National Conference on Alcohol and Substance Abuse in El Paso. Participants pointed out that farmworkers across the nation face the same barriers to treatment addressed by this project. "This kind of project is needed if rural treatment programs are going to truly open their doors and serve diverse clients," writes the project director.

The consortium, with additional representatives from other treatment and migrant agencies, will continue as a committee of an existing, larger consortium in western New York called Working Together Group. The group will continue to seek ways to improve services to farmworkers. Bilingual counselors trained through this project are finding employment in treatment agencies and will continue to be available to serve farmworkers. Referral networks will continue and the migrant health centers also will continue to offer drug and alcohol case management services. Outreach services will not continue because they are not reimbursable in New York.

A consortium of more than 40 agencies in Madison County, North Carolina, has established an address database that identifies the exact location of every structure in the county for the purpose of enhanced emergency medical response. The new system will ensure that every 911 caller in the county can be precisely located with or without verbal instructions from the caller. The project has also updated the telecommunication equipment and back-up power generators that serve the county's 911 system.

Madison County, located along North Carolina's mountainous western border, has a total population of 17,778 individuals living in 6,514 households. The project has assigned and delivered a new address for every structure in the county and three incorporated towns. The new addresses are correlated with county road mile markers, which will greatly improve the response time of law enforcement and emergency services. The data are stored in an Enhanced Address 911 system as well as a PC-based Address Maintenance System. Both databases are maintained by the county.

Madison County awarded the mapping and addressing contract to a private firm willing to cut its fees approximately 25% by using community volunteers to offset company labor costs. A team of 70 volunteers was assembled to deliver 9,000 new address assignments door-to-door. As of May 1997, the volunteers had delivered 80% of these, and they are expected to complete the deliveries at no additional cost within one year after the grant period.

Burnout of these volunteers during the project's three-year-plus duration has caused significant problems. One volunteer remarked, "We thought this would be a project, not become our career." More thorough implementation and discussions concerning the benefits to the entire county have retained enough volunteers to almost complete the deliveries. In retrospect, writes the project coordinator, there needs to be "realistic expectations of the volunteers' abilities and the length of time the project will take."

The project used has the media and public education programs to disseminate information about the new address system. As of May 1997, the project had given six education presentations to seniors groups and schools, reaching 1,335 individuals. Consortium members also have been instrumental in educating the community.

Another challenge has been the reluctance of communities to change road names. Local governments do not want to change names when voters want to leave them the way they are.

COMMUNITY ORIENTED MAPPING AND ADDRESSING/ ENHANCED TELECOMMUNICATION (COMET)

Madison County
Health Department,
Marshall, North Carolina

Contacts:
Kenneth D. Ring, MPH,
Health Director

Eddie Fox and
Maurice McAlister,
Project Coordinators

Madison County
Health Department
140 Health Care Lane
Marshall, NC 28753
(704) 649-353

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COMMUNITY ORIENTED MAPPING AND ADDRESSING/ ENHANCED TELECOMMUNICATION (COMET)

The project has overcome this problem by educating the public that the change will enhance their personal safety.

The Madison Community Health Consortium is made up of representatives from more than 40 agencies, including the county health department (the project's lead agency), an emergency medical service, volunteer fire departments, law enforcement, and local community agencies.

Madison County government has instituted an emergency 911 service surcharge of $1.00 per phone line. This surcharge, billed by the local telephone company, will support the continued maintenance of Enhanced 911 equipment after the grant period, including the new Address Maintenance System. In the future, the county will provide all new address assignments in county building permits.

PROJECT **49**

The Hydra Outreach Demonstration Project was designed to address the endemic levels of substance abuse, tuberculosis, and HIV/STDs in the farmworker population in Johnston, Harnett and Sampson Counties, North Carolina. To combat these three health problems, the project has developed an interdisciplinary array of treatment and preventive services, including case management, screenings, outreach, and prevention education.

Comparing these three diseases to the mythical Greek monster Hydra, from which the project takes its name, the project director writes, "all levels of the three-headed dragon must be dealt with simultaneously to reduce the threat of these diseases in the farmworking community."

By drawing upon the expertise and services of its consortium members, the project provides medical follow-up and case management for tuberculosis patients, case management for HIV-infected individuals, and substance abuse services. All services are provided at the Tri-County Community Health Center, a clinic whose sole purpose is to serve the biopsychosocial needs of migrant and seasonal farmworkers and their families in the three counties. The clinic, which also provides dental services on site, is located about 50 miles from Raleigh in the heart of this remote, agricultural region. Tuberculosis medication is also distributed at labor camps.

One of the project's primary goals was to develop and maintain a trusting relationship with farmworkers and growers in the community. A physician, mid-level provider, and health educator visit the camps each year, providing general health assessments, screenings, education, and prevention materials. The project works with the crew leaders, growers, and farmworkers to establish convenient times to visit the camps. About 2,300 farmworkers receive services through these visits each year.

The project also participates in a farmworker festival each August, which draws about 600 participants. It also holds several health fairs each year in conjunction with national and worldwide disease prevention activities (e.g., Breast Cancer Awareness Month, World AIDS Day, and the Red Ribbon Campaign for substance abuse).

The most significant problem continues to be transportation. Many farmworkers lack transportation and rely heavily on the crew leader or the health center for transport. Although limited transportation is provided, some farmworkers are still unable to take

HYDRA OUTREACH DEMONSTRATION PROJECT
Tri-County
Community Health Center,
Newton Grove,
North Carolina

Contacts:
J. Michael Baker,
Executive Director
(910) 567-6224

La Tanya Dillon,
Community
Services Director

Tri-County Community
Health Center
P.O. Box 227
Newton Grove, NC 28366
(910) 567-6194

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HYDRA OUTREACH DEMONSTRATION PROJECT

time off to come to the clinic. Many of the providers saw this as a lack of interest on the part of the farmworker, when in fact it meant losing a day's pay, which many could not afford. The clinic has lifted some of this burden by offering evening appointments and by establishing a "one-stop" scheduling system in which the individual can see a medical provider, case manager, and social service worker in the same visit. Despite these improvements, continuity of care is still a primary concern.

A number of local health and social service agencies work with the Tri-County Community Health Center to serve this population. Case management of HIV-infected clients is provided by Drugs and AIDS Prevention Among African Americans (DAPAA), a community-based organization in Johnston County; and Dogwood HIV/AIDS Consortium, which is the Ryan White HIV Consortium serving Sampson and Harnett Counties. The DAPAA also provides substance abuse services and participates in the annual health screenings in the camps. Johnston County and Harnett County Health Departments manage active tuberculosis cases and distribute medication when needed. Finally, the Migrant Benevolent Association, a private, non-profit organization, provides transportation, technical assistance, and development of outreach services and health education programs.

During the last year of the grant period, the project switched its focus during the off-season (December through March) to the homebound elderly. Outreach workers visit their homes to make safety inspections, check medications, contact home health aides, and arrange for provider follow-up, if necessary.

The Tri-County Community Health Center will support the continuation of HIV outreach/case management and geriatric outreach after the grant period. The health center is also turning its attention to the debilitating effects of diabetes on the farmworker population, and is soliciting funds from foundations, state, local, and federal funding sources to address this problem.

RURAL HEALTH OUTREACH GRANT
Hoke County Health Department, Raeford, North Carolina

Contact:
Don Wobble,
Health Director

Hoke County
Health Department
429 East Central Avenue
Raeford, NC 28376
(910) 875-3717

A consortium of public and private health care providers, together with the local Board of Education, has established a school-based health clinic at Hoke County High School in the small, rural community of Raeford, North Carolina. Staffed by a public health nurse and a mental health counselor, the clinic provides much needed primary and preventive health care to the county's adolescent population. It is conveniently open from 7:30 am to 4:00 pm, five days per week.

The project's consortium collaborates to provide a network of health services at the clinic. The Hoke County Health Department, the project's lead agency, provides public health nursing services. Counselors from Sandhills Mental Health, a local mental health agency, provide one-on-one counseling services. In addition, local physicians and dentists are available to accept referrals. The Hoke County Board of Education and the high school staff provide the utilities and space for the clinic.

Services provided at the clinic include basic first aid, health assessments, appropriate follow-up and referrals, immunizations, nutrition counseling, mental health counseling, and screenings for vision, hearing, scoliosis, and dental health. Various lab tests also are available. The staff nurse assists the school health educator in providing counseling and health education classes to students. Topics include parenting, drug abuse, human sexuality, and communicable disease.

The clinic opened in November 1995, and use by students gradually increased during the school year. By the beginning of the second year, the clinic was providing services to about 200 students per month. As of May 1997, 2,168 students had received services at the clinic, and 68 students had been referred to other providers.

The consortium has been unable to provide or raise sufficient funds to support the clinic after the grant period. "Our community is small and our economic resources are limited," writes the project director, "yet the rural health outreach grant assisted our community in accomplishing something that would never have been achieved otherwise. We feel that the project was a success."

PROJECT **51**

IMPLEMENTATION OF CRITICAL PATHWAYS IN RURAL MENTAL HEALTH IN NORTH CENTRAL NORTH DAKOTA

St. Aloisius Medical Center,
Harvey, North Dakota

Contact:
Sister Suzanne Stahl, LCSW,
Coordinator

Rural Mental
Health Consortium
600 17th Avenue, SE
Minot, ND 58701
(701) 857-2199

This outreach project is the first program in North Dakota to use nonphysician primary care providers with prescriptive authority to provide mental health services in an independent setting. Two clinical nurse specialists provide assessment, intervention, and ongoing management of mentally ill patients in 13 locations throughout the north central portion of the state. Before this outreach project, only four communities in this 11,500-square-mile area offered mental health services, and there was very little outreach to the surrounding rural and frontier population.

One of the project's foremost priorities was to train two psychiatric nurses to obtain their credentials as clinical nurse specialists. These specially trained individuals are the only nonphysician primary care providers in the state who can prescribe psychotropic medications, provide counseling, and who are third-party reimbursable. The ability to provide all these services in combination makes these specialists so beneficial in the delivery of mental health care, particularly in this region where recruitment of physicians, psychologists, and licensed clinical social workers is so difficult.

Under the grant, the two nurses received their masters degree, passed their certification exam, worked the required number of hours under physician supervision, and received prescriptive authority. Together with the project coordinator (a licensed clinical social worker) they provide mental health services in 13 rural locations. Services include mental health assessment and diagnosis, medication prescription and management, and therapy and behavioral intervention to individuals, families, and couples.

As of May 1997, the project's mental health professionals had conducted 7,986 client visits. About one-quarter of the project's clients are Native American, and half of all service delivery sites are located near or on reservations. Because referrals for services come from local physicians, pastors, friends, and family, a positive reputation in the local communities has been critical to the project's success.

Because the stigma associated with mental illness is a significant barrier to obtaining treatment, the project made education of health professionals and the general public a major focus. As of May 1997, project staff had given presentations to 4,192 individuals in nursing homes, hospitals, schools, and other community sites. One significant lesson learned is that attendance is highest when the local community decides on the program, there is a

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PROJECT 51

IMPLEMENTATION OF CRITICAL PATHWAYS IN RURAL MENTAL HEALTH IN NORTH CENTRAL NORTH DAKOTA

great deal of marketing, and the program is linked to an already scheduled group event.

One obstacle encountered by the project has been resistance to the use of clinical nurse specialists. This has necessitated vigorous education of medical and health care professionals, consumers, and also the state legislature, which continues to question the financial and practice issues surrounding the use of nonphysician primary care providers.

The project's greatest ongoing problem, however, is the distances between the 13 sites and the harsh winter climate. Traveling to these sites, whether by car or plane, consumes time, money, and energy, not to mention placing staff members in dangerous travel conditions. The amount of time the clinicians spend traveling cuts their direct services time significantly, making it difficult to receive enough reimbursement from third-party providers to achieve financial solvency. Telemedicine is being explored as a possible solution to this problem.

The project's consortium is led by St. Aloisius Medical Center located in Harvey, North Dakota. Other members include St. Andrew's Health Center in Bottineau, Kenmare Community Hospital in Kenmare, and Presentation Medical Center in Rola and Rolette. UniMed Medical Center, while not part of the consortium, has been instrumental in the project's success by offering acute and emergency psychiatric services with a 24-hour emergency access line.

Both the direct mental health services and the educational component of the project are expected to continue after the outreach grant expires. Support is expected through third-party reimbursement, contracts with nursing homes, grants, and monies earned from educational workshops. A third clinical nurse specialist was hired in April 1997, and in August 1997, the number of treatment sites was expanded to include six additional nursing homes.

PROJECT **52**

Kidder County, North Dakota, is a frontier area covering 1,440 square miles of prairie. Before this outreach project, access to health care was a major difficulty for many of its 3,332 residents. Primary and preventive services were available only in Steele, the county seat, and only for 3.5 days per week. Residents had to travel 50 to 80 miles to Bismarck or Jamestown to receive major medical care.

The project established a rural nursing center in five communities throughout the county — four in county schools and one in a senior center. Each nursing center is open one day per week, staffed by a nurse practitioner employed by the project. Two of the centers are open one evening per week. The project also provides a school nurse who visits all five Kidder County schools one day per week. The establishment of these clinics ensures that all major population sites in the county have access to health care and referral services. Staff keep some replenishable supplies at each site and use a van to transport other supplies and major pieces of equipment between sites.

The nurse practitioner provides a range of primary and preventive services, including treatment of acute illness, routine physicals, sports physicals, newborn and well child exams, gynecology services, obstetrics checks, health education, and referrals. She also treats chronic illness such as diabetes, hypertension, heart disease, cancer, and asthma. Public health nurses transport patients to the nearest clinic if necessary, and home visits are provided when no transportation is available. The clinics are open to all county residents.

As of May 1997, the nurse practitioner clinics had provided 589 acute and chronic health care services. This number reflects nine months of clinic operation.

The project's greatest challenge was recruiting a nurse practitioner. The recruitment process took one year, putting the project a year behind schedule. However, the project did hire a school nurse during the first year, which brought an additional benefit to the community not originally planned in the grant. Both the nurse practitioner and the school nurse will continue to provide services after the grant period.

Another challenge was educating the public about the capabilities of nurse practitioners and their collaborative role in the health care team. "People have ingrained ideas about how health care is delivered and by whom," writes the project director. Some people mistakenly believe that nurse practitioners are like nurses and,

PRIMARY HEALTH CARE CLINICS
Kidder County District Health Unit, Steele, North Dakota

Contacts:
Anne Iszler, RN, Administrator

Barbara Hahnemann, PhD, RN, CNP

Kidder County
District Health Unit
P.O. Box 52
Steele, ND 58482
(701) 475-2582

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PROJECT 52

PRIMARY HEALTH CARE CLINICS

therefore, their services should be free. Use of the nurse practitioner clinics has developed over time as satisfied clients refer others to the nursing centers.

The Kidder County District Health Unit serves as the project's lead agency. Five county schools complete the consortium.

The Kidder County District Health Unit will continue to support the school nurse program after the grant period. St. Alexius Medical Center, a private medical facility in Bismarck, will support the nurse practitioner clinics. Reimbursement for services will continue through health insurance, Medicare, Medicaid, and private pay. Gaming funds and public donations are also expected.

PROJECT **53**

A consortium of health and social service providers in Adams County, Ohio, are sharing a mobile unit to provide services throughout this rural county. A team consisting of a nurse practitioner, public health nurse, and social worker visit community halls and other meeting places eight days per month, providing health education and disease prevention services on board the mobile unit, as well as information and applications for social service programs. The project serves all county residents, and targets children and the elderly in particular.

The impetus behind this project was a severe shortage of health care professionals in the county, particularly those willing to accept Medicaid clients. Adams County has high rates of poverty, unemployment, and chronic disease in both children and adults. Many residents lack transportation to travel to health care providers.

The project has one paid staff person, a nurse practitioner who also serves as project director and driver. This individual is well known and respected throughout the county, and this has been vital to the acceptance of the program. Her services are provided through a contractual agreement with the Adams County Health Department.

Health care services provided on the mobile unit include adult and child immunizations, blood pressure checks, cholesterol screening, blood sugar screening, pregnancy testing, tuberculosis testing, colorectal screening, nutrition counseling, and health education. Since the project's inception, staff have found elevated cholesterol levels in 63% of all clients tested, elevated blood sugar levels in 39% of clients tested, and elevated blood pressure in 35% of clients tested. The project mails all test results to the clients' private physicians.

Several consortium members donate the services of social workers and public health nurses to the project. These additional services include WIC certification, voter registration, and eligibility screening for Head Start and other social services.

Consortium members have found the mobile unit to be an effective and efficient method of service delivery. As of May 1997, almost 5,700 individual clients had received services (some of these are repeat clients). The most common services provided have been blood pressure checks (2,700 clients), tuberculosis tests (1,700 clients), immunizations (895 clients), health education (1,700

ADAMS COUNTY RURAL HEALTH OUTREACH PROGRAM

Adams-Brown Counties Economic Opportunities, Inc., Georgetown, Ohio

Contacts:
Nancy Darby,
Deputy Director
(937) 378-6041

Carolyn Work,
RN-PNP
(937) 544-5547

Adams-Brown Counties
Economic Opportunities, Inc.
200 South Green Street
Georgetown, OH 45121

PROJECT **53**

ADAMS COUNTY RURAL HEALTH OUTREACH PROGRAM

clients), referrals to health and social service providers (1,800 clients), and WIC enrollment (390 clients).

The project's lead agency is Adams-Brown Counties Economic Opportunities, Inc., a community action agency. Other members are the Adams County Health Department, Adams County Hospital, Southern Ohio Health Services Network, and Adams County Department of Human Services.

The project's greatest challenge has been bad roads and inclement weather, two things out of its control. Almost all the roads in the county are one lane and made of gravel or dirt. At times the project has had to change sites and/or hire an experienced driver. When ice, snow, and floods leave the roads impassable, the project announces scheduling changes on the radio.

The consortium will continue to provide health and social services on the mobile unit after the grant period. The number of days will be reduced from eight per month to four, however, with the other four days per month devoted to fund-raising activities. The consortium is seeking funding from foundations and corporate sponsors and is applying for certification to receive third-party payments.

PROJECT **54**

PREBLE COUNTY HEALTHY BEGINNINGS
Preble County Department of Health, Eaton, Ohio

Contact:
Teresa O'Diam, RN

Preble County Healthy Beginnings
119 Barron Street
Eaton, OH 45320
(937) 456-5160

The Preble County Department of Health began the Healthy Beginnings project to address the alarming rates of child abuse and neglect in this small rural community in Ohio. In 1991, 215 cases of child abuse — a 98% increase from the previous year — were reported in this population of 40,000. New and expectant mothers in this county have minimal medical and social services available to them. The county has no hospital, urgent care center, public transportation, or family planning services. Expectant mothers must travel outside the county to give birth. To help address at least some these needs, this outreach project offers early in-home health assessment, education, and support to expectant and new parents.

Project nurses provide in-home visits to new mothers and their infants, and to pregnant women with special needs. A nurse is available 24 hours by phone to provide additional support to new parents. The project also offers parent support classes; vision screening for infants and toddlers; and transportation to medical appointments for pregnant women and children up to 18 years of age. Finally, health screenings are provided to children taken into protective custody by Children's Protective Services.

The project conducted 550 home visits between March 1995 and May 1997. About 25% of the new mothers and babies assessed were found to require further instruction, assessment, or treatment by a health care professional. Some of the most common problems were jaundice, feeding problems, respiratory problems, post-partum complications, and enviro. mental concerns. Evaluations filled out by these new parents reveal an overwhelming appreciation for the home visits, and a strong willingness to recommend the program to friends.

During this time span, the project also provided 867 transports to medical appointments. Two hundred infants and toddlers received vision screening and 225 individuals attended the parenting classes.

An outreach program such as this could work well in other rural areas, notes the project director, particularly if there were a single hospital where most women delivered. Because women in this community travel to one of 11 out-of-county hospitals to give birth, the project has had to develop relationships with each of these hospitals to identify new mothers. To overcome this obstacle, the project relies heavily on referrals from county agencies and organizations who may come in contact with new

PROJECT 54

PREBLE COUNTY HEALTHY BEGINNINGS

or expectant families. Advertisements in local newspapers and cable TV, and referrals from friends and family members have also brought in clients.

Nurses from the Preble County Department of Health, the project's lead agency, provide the home assessment and education services. Other consortium members include Early Intervention, a non-profit agency that provides developmental screenings and additional support for new parents; Children's Protective Services, which provides parenting classes and investigates reports of neglect and abuse; and the Preble County Community Action Committee, which provides housing for the program and drivers for the transportation service.

Using a variety of funding sources, the consortium expects to continue all project activities after the outreach grant expires. The home nurse visits are reimbursable under Medicaid and private insurance, and a grant received from the March of Dimes will further support this program. Funds from the Early Intervention Program and the County Department of Human Services will support the transportation component. The county Lions Clubs will support the vision screening program.

PROJECT **55**

A consortium of four county health departments and other agencies has implemented a multi-dimensional approach to the problem of teen pregnancy. The project's medley of programs to teens, parents, and professionals has reached thousands of individuals in this rural, northwestern Ohio region.

A 1989 Youth Needs Assessment conducted in the four counties found that 35% of 9th graders and 67% of 12th graders reported being sexually active. Of those stating they had sex, 64% said they never used birth control. Health Department statistics from the same four counties indicated a teen pregnancy rate of 13.82% in 1993, higher than the state average.

Program services include home-based counseling for pregnant or parenting teens and their families, provided by the Four County Family Center, a consortium member. Additional support for teen parents includes "Building Blocks," a learning and sharing session for teen parents and their children; and the GRADS (Graduation, Reality, And Dual-role Skills) Support Program, an in-school program for pregnant and parenting students.

"Baby Think It Over," a program widely embraced by the schools, uses a computerized infant simulator doll to provide students with a 48-hour parenting experience. Nearly every school in the four-county area participated in this program, reaching 1,300 students. Two counties also participated in the 8th Grade Vignette Program, in which high school drama students help write and produce skits about the consequences of sexual involvement, and then present these skits to 8th graders.

Another project component trains individuals to facilitate a five-week Parent-Child Sexuality Class for parents and children to take together. Eighteen classes have been offered so far and 47 people have been trained as facilitators.

Much of the project's success is attributed to its broad base of community support, coming from clergy, school counselors, teachers, health professionals, social workers, youth leaders, and pregnancy prevention educators. The consortium spent four to six months building awareness, developing programs, and recruiting volunteers. Community leaders responded by "taking ownership of the prevention programs and promoting them by networking and volunteering their time," writes the project director. Support from church leaders was especially critical for community acceptance.

OH

RURAL HEALTH OUTREACH DEMONSTRATION PROGRAM

Henry County/
Napoleon City
Combined Health District,
Napoleon, Ohio

Contacts:
Hans Schmalzried, PhD,
Health Commissioner

Lisa Sugg,
Fiscal Coordinator

Henry County/
Napoleon City
Combined Health District
Hahn Center
104 East Washington Street,
Suite 302
Napoleon, OH 43545
(419) 599-5545

PROJECT **55**

RURAL HEALTH OUTREACH DEMONSTRATION PROGRAM

One of the most important lessons learned from the project is that it is sometimes necessary to change program components in order to meet the specific needs of sub-groups within the community. The project made these changes to achieve its overriding goal of increasing awareness. The strategy resulted in an inconsistent approach throughout the service area, however, complicating program-wide evaluation.

The Henry County Health Department leads the consortium and provides space, equipment, and clerical and fiscal support. Other members include the health departments from Fulton, Defiance, and Williams Counties; the Four County Family Center, a mental health agency; and the GRADS program for pregnant and parenting students. The Medical College of Ohio's Office of Area Health Education oversees the project's evaluation.

After the outreach grant expires, funding from Ohio's Family and Children First Council Wellness Block Grant will help support some project activities. Counseling services will no longer be available, but referrals and support programs maintained under the block grant could assist these individuals. The four county health departments brought together through this outreach grant will continue to meet as a consortium.

Seven health and service agencies of the Osage Nation are collaborating to address four serious health care needs in Osage County, Oklahoma. First, many homebound Native Americans lack home health care. Second, the county has a high incidence of suicide and depression among rural adolescents and elders. Third, the county's preschool children need improved access to mental and physical health services. The fourth problem is alcohol and drug abuse in the workplace.

Osage County is one of the largest counties in the United States, covering 2,277 square miles. Many types of health care services are not easily accessible or even available. This problem was compounded in 1994 with the closing of the Osage County Health Department. This affected the entire county, and hit the Native American community especially hard. Through coordinating services, the Osage Nation has improved access to patient care and health education, while preventing the duplication of services.

The project provides home health care and meals on wheels to all eligible Native American elderly and homebound clients referred to the outreach program. A home health aide provides assistance with daily living, and licensed professionals provide skilled nursing care, physical therapy, occupational therapy, speech therapy, mental and physical health screening, and mental health counseling. As of May 1997, the project had provided home health care services to 3,500 clients.

The project also provides mental health services to youth ages 12-19. This includes an innovative one-day summer camp that uses cultural art and recreation to build self-esteem and teach problem solving, goal setting, and teamwork. The project had sponsored eight such camps as of May 1997, with 400 participants total.

The project also contracts with mental health professionals to provide observation, assessment, and counseling for preschool age children and their families, as well as consultations with staff and teachers. Seven Head Start facilities throughout the county participate in the program. A total of 191 students receive services annually. The program also provides physical health screening to this population through the Indian Health Service.

As of May 1997, the project had provided mental health services to 500 clients. Every age group, from preschool to the elderly, had been served.

OSAGE RURAL HEALTH OUTREACH PROGRAM

Osage Rural Health Outreach Program — Osage Nation, Pawhuska, Oklahoma

Contacts:
Michael Shackelford, RN

Cindy Willard,
WIC Director

Osage Rural Health Outreach Program — Osage Nation
627 Grandview
Pawhuska, OK 74056
(918) 287-2564

PROJECT **56**

OSAGE RURAL HEALTH OUTREACH PROGRAM

To address the fourth problem of alcohol and drug abuse in the workplace, the program provides workplace testing to tribal employees and employees of private businesses. The outreach program is the only qualified drug and alcohol screening collection site in the area.

Other project activities include blood pressure screenings held several times a month at senior citizen nutritional centers, discount stores, and other community locations. Most of the clients tested are elderly. Osage Nation Social Services assists clients in applying for assistance through tribal, state, and federal programs. In addition, the Osage Nation Community Health Representative Program transports clients to health care appointments. About 4,150 county residents have participated in the project's health fairs, immunization programs, summer camps, and blood pressure clinics.

The project's consortium is made up of federally funded programs administered by the Osage Nation. Members are the Indian Health Service, Osage Nation Head Start, Osage Nation Community Health Representative Program, Osage Nation Title VI Nutritional Center, Osage Nation Social Services, Osage Nation Alcohol and Drug Abuse Program, and Osage Nation Indian Child Welfare Program.

Providing services across the vast county area has been the project's greatest challenge. To minimize travel time, the project has hired health professionals who live in the various communities where services are being delivered.

The Osage Rural Health Outreach Program will continue after the grant period, supported by third-party billing and private payments. In November 1995, the program became certified to receive Medicare reimbursement. After the grant period, the project will contract with the Oklahoma Department of Human Services and the Long Term Care Authority of Tulsa to provide home and community-based services to frail elders and adults with physical disabilities. The Advantage Program attends to clients' personal, social, and health care needs, helping them to continue living as independently as possible. Program services are Medicaid reimbursable.

PROJECT **57**

The Pediatric Outreach Rural Health Clinic was established in 1995 to provide primary care services to children of the so-called "working poor" — families who work in low-paying jobs without health insurance, but who make too much money to qualify for Medicaid or other government health programs. This ever-growing group poses one of the most fundamental challenges to the health care system in south central Oklahoma. The outreach clinic serves a seven-county region and is located in the Pontotoc County Health Department, the project's lead agency. Patients are charged on a sliding fee scale tied to income.

Some of the services available at the clinic include sick care, well child exams, lab work, immunizations, hearing evaluations, developmental screenings, parent counseling, and patient education. In 1996, the clinic expanded its target population to include adults. As of May 1997, the clinic had treated more than 1,200 uninsured individuals.

A team of part-time primary care providers staff the clinic on a rotating schedule. A physician's assistant and a nurse practitioner each see patients eight hours per week. They are supervised by the medical director of the Pontotoc County Health Department, who also serves as the clinic's medical director. This physician sees clinic patients two hours per week and assumes primary responsibility if a patient is admitted to the hospital. A registered nurse is available 24 hours per week to assess patients and provide immunizations. Finally, two specialists visit the clinic periodically to provide hearing and developmental screenings.

One of the clinic's most significant problems has been a lack of public awareness and use of services. About 40 patients currently use the clinic each week — the highest patient load since the clinic's inception. This number is far below the clinic's maximum capacity of 150. One of the reasons for this problem is that the clinic does not have a budget for paid advertising, and the area's media, not understanding the mission and financial status of the clinic, insists that the clinic pay for its ads.

On the positive side, however, the clinic has established strong working relationships with local organizations and schools. The Head Start Program, Salvation Army, Ada Area Youth Shelter, women's shelter, and several area schools often refer individuals to the clinic. The health department, the project's lead agency, is a natural source for referrals.

PEDIATRIC OUTREACH RURAL HEALTH CLINIC
Pontotoc County Health Department,
Ada, Oklahoma

Contacts:
Steve Childress,
Administrative Director
(405) 332-2011

Lori Sweeny, RN
(405) 332-6976

Ellen Griffin,
Office Manager
(405) 332-2011

Pontotoc County
Health Department
1630 East Beverly
P.O. Box 10
Ada, OK 74820

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PROJECT **57**

PEDIATRIC OUTREACH RURAL HEALTH CLINIC

Another difficulty has been that even though the clinic has made it possible for hundreds to receive diagnoses for their medical problems, many patients cannot afford the medicines to treat their illnesses. As a short-term solution, the clinic's registered nurse arranged for the donation of thousands of dollars of free antibiotics from Eli Lilly Company and other drug manufacturers. These have been dispensed without charge to clinic patients. In the future, if funding is obtained to continue services after the outreach grant expires, the clinic intends to provide for medications and diagnostic procedures in its budget.

The Pontotoc County Health Department joined forces with two health care professionals to form the consortium: the medical director for the health department, and an audiologist who practices at Carl Albert Indian Hospital.

Project staff hope that the clinic can continue to provide services using a fee-for-service, sliding fee scale after the outreach grant expires. This system does not generate sufficient income to support the clinic, however, and outside funding will be critical for the clinic's survival. The consortium has asked the Oklahoma State Legislature to provide funding for next year. This prospect looks favorable.

PROJECT **58**

RURAL HEALTH TRANSPORTATION
Pontotoc County
Rural Health Coalition,
Ada, Oklahoma

Contacts:
Dr. Elizabeth Schmelling,
Project Director
Chair, Department of
Nursing Education
East Central University
(405) 332-8000

Jonne Mae Stewart,
Call-A-Ride
704 North Oak, Room 8
Ada, OK 74820
(405) 332-7056

In 1992, a task force commissioned by the Oklahoma Department of Health identified lack of transportation as the most significant problem in the provision of health care services in the state's rural areas. Pontotoc County, in the southeastern part of the state, is a prime example of this need. Before this outreach project, this rural county had no public transportation system outside Ada, the county seat. Individuals without transportation faced significant difficulties in traveling to a physician, dentist, optometrist, or pharmacy.

To address this need, the county purchased two vans to provide door-to-door transportation throughout the county for non-emergency health-related trips. Fares range from $0.35 to $0.85, depending on age. (Children and the elderly receive the lower fare.) Rides must be requested 24 hours in advance. Services are provided through Call-A-Ride, a county-operated public transportation service in Ada.

In another component of this project, Valley View Hospital offers screening programs and immunizations at the hospital and at other rural sites such as nutrition centers and schools. Services include influenza and pneumonia inoculations, and screenings for cholesterol, prostate cancer, hearing, high blood pressure, and Alzheimer's disease. Faculty and students in the Nursing Department of East Central University take part in the screenings and help counsel persons who are found to have high levels of cholesterol or high blood pressure.

As of May 1997, the transportation program had provided 11,750 rides, and 3,660 individuals had participated in the project's immunization and screening programs. Both figures far exceeded project goals. Three-quarters of all project participants are elderly, and 90% are women.

Because Pontotoc County is the grantee, the County Commissioners direct the grant. Call-A-Ride, which is under the jurisdiction of Pontotoc County, coordinates and supervises project activities. Other consortium members are Valley View Hospital, a regional non-profit hospital, and the Nursing Department of East Central University, a state-supported university. According to the project director, the transportation program was easy to implement because the county already had a public transportation agency in place, and because it was a demand/response program rather than a fixed route operation.

Because of the highly favorable public response, the Pontotoc County Commissioners have agreed to support the transportation

PROJECT **58**

RURAL HEALTH TRANSPORTATION

program after the grant period, including maintaining the vehicles and paying the drivers' salaries. The county will probably request funding from the Oklahoma Department of Transportation to help support the program. Valley View Regional Hospital will continue to offer screening and immunization programs at rural sites, with assistance from the faculty and students of East Central University's Nursing Department.

PROJECT 59

AN INNOVATIVE MODEL OF PRIMARY HEALTH CARE DELIVERY TO A RURAL POPULATION INVOLVING A COALITION AND HOSPITAL AFFILIATION

The Upper Rogue Community Center, Shady Cove, Oregon

Contacts:
Margaret "Peg" Crowley, MPH, RN,
Executive Director

Community Health Center
19 Myrtle Street
Medford, OR 97504
(541) 773-4563
(541) 776-2892 fax

The Upper Rogue Region Community Center
22465 Highway 62
Shady Cove, OR 97539

The Upper Rogue Region in southwest Oregon encompasses the rural and isolated communities of Shady Cove, Trail, Prospect, Union Creek, and Butte Falls. For many decades, these timber-dependent communities had enjoyed the services of a family physician. When the communities' physician retired in November 1989, however, the physician search committee was unable to recruit a replacement. The two primary reasons stated by applicants for rejecting the position were the continuous 24-hour per day call schedule and the lack of transportation for patients needing hospital services. The committee's search continued for four years without success. During this time, the Upper Rogue Region was federally classified as both a Health Professional Shortage Area and a Medically Underserved Area.

In early 1994, four local providers of health and human services formed the Upper Rogue Health Care Coalition to assist the physician search committee. These entities proposed the following potential solution to the physician recruitment problem: Providence Medford Medical Center, a tertiary care center in Medford, would open a primary care practice in Shady Cove staffed by a mid-level practitioner and a physician. The medical center's emergency department would provide after-hours services, and a group of physicians affiliated with the medical center would provide inpatient care. The Upper Rogue Community Center would transport patients to medical specialists and other ancillary services in Medford. Finally, the Jackson County Department of Health and Human Services would provide adjunct services on-site at the health center, including lead testing, WIC services, well child examinations, and immunization programs for children and seniors.

The Providence Shady Cove Health Care Center opened in September 1994, funded by the outreach demonstration grant. It provides a full menu of primary and preventive health care services to the region's 26,000 residents, as well as diagnostic radiology and laboratory testing. The center was staffed initially by one full-time physician assistant and a .20 FTE physician. In 1997, the project was able to recruit a full-time physician to the clinic, and this has helped to increase program revenue.

As of May 1997, the project had provided 4,413 primary care office visits at the health center, 1,044 transportation services, 752 home health care visits, and 744 public health services. According to the project director, the new health center has

PROJECT 59

AN INNOVATIVE MODEL OF PRIMARY HEALTH CARE DELIVERY TO A RURAL POPULATION INVOLVING A COALITION AND HOSPITAL AFFILIATION

significantly addressed the problem of access to primary health care in the region.

"Having a major hospital as an involved member of the coalition was a critical ingredient in this project's success," writes the project director. "The hospital was able to remove many of the barriers to physician recruiting and retention by offering its staff for after-hours services, on call services, and inpatient services. It was relatively simple to recruit a physician after these barriers had been addressed."

The Upper Rogue Health Care Coalition consists of the Upper Rogue Community Center, the project's lead agency; Providence Medford Medical Center; Jackson County Department of Health and Human Services; and the Community Health Center, a non-federally-funded, sliding-fee-scheduled, not-for-profit primary care clinic with offices in Medford and Ashland.

The Providence Shady Cove Health Care Center will continue to provide primary and preventive health care services after the outreach grant period. The health center's revenue has increased steadily during the outreach project, and that tread is expected to continue. The Sisters of Providence, the charitable organization that funds the Providence Medford Medical Center, is committed to supporting the health care center to assure its long-term sustainability. The project's coalition will also continue its community involvement, with emphasis shifting from launching a primary care clinic to identifying gaps in services and arranging to fill those gaps.

Union, Oregon, once a prosperous and economically healthy town in eastern Oregon, experienced an economic downturn in the 1980s that led to a significant loss in local services, including the town physician and dentist. In the early 1990s, the Department of Human Resources listed Union County as the fifth "most needy" primary care area in Oregon. A large percentage of its nearly 4,400 residents live below the poverty level. The town of Union has one of the highest concentrations of elderly in the state.

In response to these needs, the Oregon Health Science University School of Nursing, located 15 miles from Union, established the Union Family Health Center, a certified Rural Health Clinic staffed by nurse practitioners. The clinic, which also serves as a practice site for health professional students at the School of Nursing, has resulted in a win-win situation for the community and the school, writes the project director. The community has benefited from the renewal of primary care services. Many at the School of Nursing, including faculty, graduate level nurse practitioner students, and undergraduate nursing students, have gained valuable practical experience at the clinic. The school has also used the clinic in formal research studies examining the effectiveness of nurse practitioners in providing primary care to rural communities.

The clinic provides primary health care services, health education, and health promotion activities to Union and the nearby towns of Cove and North Powder. Three nurse practitioners work at the clinic on a rotating schedule, and teach at the university on alternating days. As of May 1997, the clinic had provided services to 2,700 patients in 8,869 primary care patient visits.

The project also offers clinic clients a number of mental health and public health services provided through the Center for Human Development in Union County. These services, which include alcohol and drug counseling, seniors counseling, teen parenting skill-building sessions, and family counseling, are provided at other locations because of overcrowding at the clinic. The organization also provides WIC services at the clinic four hours per month. Finally, Grande Ronde Hospital, a non-profit hospital in La Grande, 15 miles from Union, makes available emergency, laboratory, and x-ray services to the health center.

Clinic staff, faculty, and students also provide health education programs targeted to specific age groups or occupations. Topics

RURAL HEALTH OUTREACH PROGRAM

Oregon Health Sciences University School of Nursing at Eastern Oregon State College, La Grande, Oregon

Contacts:
Jeanne Bowden,
Associate Dean
(541) 962-3384

Carol Grubbe,
Office Manager
(541) 562-6062

Oregon Health Sciences University at Eastern Oregon University
1410 L Avenue
La Grande, OR 97850

RURAL HEALTH OUTREACH PROGRAM

include health career exploration for high school students, logging health and safety, and EMT education. As of May 1997, the project had offered 102 educational programs with a total of 553 participants.

The health center's role as a practice site for School of Nursing faculty and students is unique in this rural area. Each family nurse practitioner student spends at least 60 hours of his or her clinical practicum at the clinic. As of May 1997, 15 nurse practitioner students had provided 1,106 hours of primary care at the center. Every undergraduate student also rotates through the clinic for at least two days.

One of the greatest benefits of the project's alliance with the School of Nursing has been the creative efforts of its nursing students. Undergraduate students have assisted with community assessment surveys; acted as school nurses in Union, Cove, and North Powder; planned and implemented health fairs and immunization clinics for influenza and hepatitis B; and performed lead screenings of children. Graduate students have completed special research projects in needs assessment and outcomes evaluation concerning nurse-practitioner primary care clinics.

Oregon Health Sciences University serves as the project's lead agency. Other consortium members are Union Family Health Center; the Center for Human Development; Union School District; City of Union & Union Volunteer Ambulance Service; Grande Ronde Hospital; Oregon State University Extension Service, a farm and home information service; and Northeast Oregon Area Health Education Center, a provider of education opportunities for health care professionals.

After the grant period, the clinic will continue to provide primary care to the community and serve as a practice site for faculty and students. The clinic needs to see 23 patients per day to reach self-sufficiency, and is now close to this goal. Further marketing efforts, coupled with an increasing population in the area, are expected to bring more business to the clinic.

Health promotion activities and outcomes research/evaluation will also continue as part of the service mission of the University. A research team at the School of Nursing is conducting a study funded by the National Institute of Nursing that examines health risk reduction and other outcomes in patients treated at the nurse practitioner clinic.

PROJECT **61**

SIUSLAW COMMUNITY CONNECTION PROJECT / FLORENCE FAMILY RESOURCES

Peace Harbor
Hospital Foundation,
Florence, Oregon

Contacts:
James Barnhart,
Administrator

Sara J. Seaman,
Project Coordinator

Peace Harbor
Hospital Foundation
P.O. Box 580
400 Ninth Street
Florence, OR 97439

For many years, mental health and substance abuse programs in western Lane County, Oregon, have faced an overwhelming demand for services. Many of these programs are understaffed, poorly funded, and restrict their services to narrowly defined mental health problems. Individuals seeking help have encountered complicated eligibility requirements and received inappropriate referrals. Still others, particularly the poor, have been turned away because of their inability to pay.

Several years ago, a group of these providers decided that although there was little hope of expanding funding for their rural organizations, they could at least address the confusion and "run around" experienced by their clients. They formed a consortium with the goal of combining their resources and restructuring the delivery of services within the community.

The consortium's most innovative solution, and the basis for the outreach project, is a single point of entry for the entire service area. In a single appointment, project staff conduct a mental health assessment and determine the best combination of physical, mental health, or human services available to individuals and families. The project then makes appropriate referrals to local providers. It also assists the client in accessing services outside the community if their problem exceeds the scope of practice of local service providers.

The project targets those individuals who traditionally have had difficulty accessing mental health and substance abuse services, namely the poor and the elderly. Services are provided in the town of Florence, yet the project also serves the residents of four nearby communities, as well as rural residents.

In many cases, individuals present with urgent mental health needs, yet the project cannot make a referral because the client does not meet the provider's narrow criteria for diagnosis or ability to pay. In these instances, the Siuslaw Community Connection Project takes on the client and provides appropriate services. The project is capable of providing a comprehensive array of mental health services, including mental health crisis response, substance abuse assessment, outpatient treatment for the chronically mentally ill, medication monitoring, group and individual therapy, and detoxification assistance (outpatient and inpatient).

As of May 1997, the project had assessed 169 individuals. The Community Connection outreach project provided direct mental

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PROJECT 61

SIUSLAW COMMUNITY CONNECTION PROJECT / FLORENCE FAMILY RESOURCES

health services to 122 of these individuals. The project referred 40 others to consortium members, and the remaining seven people declined follow-up services.

The Community Connection is located in Peace Harbor Hospital, the project's lead agency. The hospital has benefited from the project because "local residents currently unable to access primary care, mental health or substance abuse services ultimately find their way to the hospital's emergency room," writes the project coordinator. "The project provides a more appropriate and less costly approach to the delivery of mental health and social services."

Other consortium members include Health Associates, a hospital-based primary care practitioner clinic; the Siuslaw Pacific Center for the chronically mentally ill; two counseling programs for teens and children; a domestic violence assistance program; a home health and hospice program; and a substance abuse program.

Initially, several consortium members voiced concern that the project would refer paying and non-paying clients in unequal numbers. The consortium resolved this issue by asking each member to advise the committee of their minimum fee, their criteria for service, and the maximum number of pro bono cases they could accept. The project then kept all referrals within these limits.

A more persistent problem has been the instability brought on by Oregon's state-sponsored managed health care plan and the creation of numerous health management organizations (HMOs). Access to services has improved for some individuals, while others who had been receiving services now find their coverage denied. While increased competition can be a healthy impetus for change, writes the project coordinator, it has had a negative effect on the consortium by forcing members to compete against each other for limited dollars. The project has not found any immediate solutions to these challenges.

The Community Connection will continue to provide mental health services to its target population after the outreach grant expires. The project has applied for a Medicaid Mental Health Contract under the Oregon Health Plan. Funding is also expected from third-party payments, grants, and a sliding fee schedule.

PROJECT **62**

COMMUNITY-BASED APPROACH TO STRENGTHENING RURAL HEALTH SERVICES

St. Bernard's
Providence Hospital,
Milbank, South Dakota

Contacts:
Lisa Campbell,
Executive Director

Bryan Schmidt,
Co-Director

St. Bernard's
Providence Hospital
901 East Virgil Avenue
P.O. Box 423
Milbank, SD 57252
(605) 432-4538
(605) 432-5412 fax

This South Dakota outreach project is based on the community health services development model pioneered by the Kellogg Foundation in rural Washington State. The hallmark of this model is a comprehensive community-wide survey to determine the health care needs of the area. Information gained from this survey guides the planning and implementation of all project activities. For this project, the area of concern was the community of Milbank, in northeast South Dakota, and three surrounding counties. The population of this area is about 11,500.

The principle focus of the project is to make primary care available when and where the area residents need it. Based on the needs identified in the survey, the project opened two outreach clinics in Wilmot and Revillo (each are open 12 hours per week), expanded the hours of the existing clinic in Milbank to include one evening per week, and started a clinic in St. Bernard's Hospital on Saturday mornings. About 200 patients per month make use of these extended hours and satellite clinics. As an indication that these activities are making a difference, inappropriate use of emergency rooms has decreased from 177 visits per month in 1994 to 130 in 1996, and immunization rates have improved.

The consortium has also joined forces to recruit two family practitioners and two nurse practitioners to the area, and to retain health care professionals already in practice. One of the obstacles to physician recruitment in the past has been the reluctance of potential recruits to agree to clinic ownership, a tradition in the area. The consortium has addressed this problem by negotiating and contracting directly with physicians, and not requiring property ownership in the contract. The community survey taken at the beginning of the grant period has also been an effective recruitment tool.

One of the most significant lessons learned by the project is the importance of community involvement in planning and building the outreach clinics. Rather than seeking community help in selecting the first site, the consortium instead went with a clinic in Wilmot already under construction by the Milbank Community Foundation and Economic Development Corporation, a consortium member. The community, however, was resistant to using the new clinic, and it took some time to build public support and usage.

This experience prompted the consortium to use a more

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PROJECT **62**

COMMUNITY-BASED APPROACH TO STRENGTHENING RURAL HEALTH SERVICES

community-focused strategy in selecting the second site in Revillo. Civic groups were consulted through forums and written communication. As a result, this community has fully embraced its clinic, and growth has occurred much faster. Volunteers even stepped forward to help renovate the building chosen for the clinic.

The project's consortium consists of the non-profit St. Bernard's Providence Hospital; Milbank Medical Services, a private, for-profit clinic with three primary care providers; and the Milbank Community Foundation and Economic Development Corporation, a community foundation/industrial development company. Before receiving this grant, these three entities had already established a non-profit corporation called the Northeastern South Dakota Health Plan, and had worked together on community health issues.

Despite this history, strong philosophical differences between the non-profit, religious hospital (St. Bernard's) and the for-profit, secular clinic (Milbank Medical Services) have often placed them at odds. It is now clear that the original vision of a shared governance for the hospital and clinic will not occur because of these differences. However, consortium members are sharing governance of one outreach clinic and are working together on physician recruitment. The consortium arrangement also has created an opportunity for these dissimilar groups to address health care problems together.

After the grant period, the outreach clinics are expected to generate enough revenue to be self-supporting, and the physicians recruited to the project are expected to generate sufficient revenue to support their salaries. If any shortfalls occur, the consortium is committed to supporting these activities.

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A consortium of three state-wide agencies has provided farm safety day camps for children in every county in South Dakota. The camps are designed to teach children how to spot dangers on the farm and reduce the chance of injury or death for themselves or others. More than 14,000 children and adult volunteers have participated in 101 camps as of May 1997. Although the camps are designed to educate children ages 8-13, many adult volunteers have commented that they have also been reminded of important safety issues.

Farm safety is a critical concern in South Dakota, where one-third of the population relies on income from agricultural production. Fourteen individuals were killed on the farm in 1992 and 751 were injured. It is estimated that 14-24 percent of all fatalities on farms occur among children.

While there is a curriculum and general guidelines to follow, each community develops a unique camp to address its specific concerns. A local coordinator chooses topics and recruits speakers. The project gives each coordinator a training manual and a $250 grant to help defray the expenses of the camp. Each coordinator also attends a mandatory one-day training session. Local committees comprised of 4-H parents, older 4-H participants, and hospital personnel help the coordinator run the camps, giving the community a sense of ownership. A full-time project director working out of the Easter Seals office in Pierre oversees the program state-wide.

Much of the project's success can be attributed to the collaboration among consortium members. Providing the backbone of the project is the South Dakota State University Cooperative Extension Service, a university-based agricultural education and safety organization with its agents, who work in almost every county in the state. Although the project solicits applications for camp coordinators from the general public, an Extension Service representative has assumed this role in most counties. The Easter Seal Society of South Dakota, the project's lead agency, lends the assistance of its state-wide network of representatives. The remaining consortium member, McKennan Health Services, which is a state-wide network of non-profit rural hospitals and clinics, lends its hospital and medical personnel for camp planning and educational presentations.

Project staff note that the camps have had a measurable impact. Results of evaluations administered immediately after the

SAVE OUR FARM YOUTH
Easter Seal Society of South Dakota,
Pierre, South Dakota

Contacts:
Patricia K. Miller,
Project Director

Susan Quinn, CEO

Easter Seal Society
of South Dakota
1351 North Harrison Avenue
Pierre, SD 57501
(605) 224-5879

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SAVE OUR
FARM YOUTH

camps demonstrate that campers have learned to recognize safe farm practices. In addition, surveys mailed to parents several weeks or months after the camps reveal that parents are noting lasting changes in their children's safety practices.

The greatest challenge faced by the project has been transporting the large and heavy safety displays from camp to camp. The project alleviated this problem to some degree by purchasing several sets of each piece of equipment and keeping them at different locations throughout the state.

The farm safety day camps will continue after the grant period, with each camper charged a $5 fee. Many businesses and organizations have offered financial and in-kind donations to support the program, and the Easter Seal Society plans to conduct a major fundraising campaign.

PROJECT 64

SOUTH DAKOTA GERIATRIC FORUM

University of South Dakota School of Medicine, Rapid City, South Dakota

Contacts:
David Sandvik, MD,
Project Director
(605) 341-3140

Jane Yarbrough,
Program Coordinator
(605) 394-6927

University of South Dakota School of Medicine
3625 Fifth Street, Suite 200
Rapid City, SD 57701

The vast majority of South Dakota's elderly depend on rural health care providers and rural nursing homes for their health care needs. While these professionals are expected to provide a high standard of care in geriatrics, many find it difficult to obtain up-to-date continuing education in such isolated rural areas. The South Dakota Geriatric Forum was developed in response to the great need for quality geriatric education in the state's rural and frontier regions.

The South Dakota Geriatric Forum produces one-hour geriatric education programs for health care professionals and broadcasts them monthly throughout the state. Programs are shown on the Rural Development Telecommunications Network (RDTN), which allows for two-way audiovisual communication with 12 different sites in the state.

Midway through the grant period, a newly established Mountain Plains Distance Learning Network began transmitting Forum programs to additional nursing homes in the region using one-way satellite broadcasts. This new linkage enlarged the number of receiving sites to 147, including nursing homes in South Dakota, Wyoming, Montana, and Nebraska. Attendees at the satellite sites have access to a toll-free telephone number so they can ask questions and clarify issues.

Faculty members certified in geriatrics at the University of South Dakota School of Medicine, the project's lead agency, contribute their expertise to the programs. Other consortium members provide additional expertise in geriatrics, as well as program suggestions, and assistance with evaluation.

A multidisciplinary audience attends the programs, including physicians, physician extenders, nurses, physical therapists, other therapists, emergency medical technicians, dietitians, social workers, and administrators. Continuing education credits are awarded when requested.

The project records each program and mails the tapes free of charge to persons requesting them. Many people living out of state have requested the tapes and have commented favorably on their content.

As of May 1997, the project had broadcast 29 educational programs with 2,581 people attending; it had also mailed 528 tapes. Project staff estimate that the project has benefitted more than 25,000 elderly, possibly all the elderly in the state. More than 70 percent of those who attended the programs are nurses

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SOUTH DAKOTA GERIATRIC FORUM

and social workers. Almost all work in rural nursing homes, long-term care facilities, hospitals, the Department of Social Services, and clinics.

Because the telecommunications network had been operational for some time before the beginning of this project, very few technical problems arose. There were some scheduling difficulties because a number of other educational and government programs also have access to the telecommunications system.

Four state health care providers and two health care regulators complete the project's consortium. They include the South Dakota Medical Director's Association, which represents nursing home medical directors; the South Dakota Academy of Family Physicians; the South Dakota Association of Community Healthcare Centers; the South Dakota Home Healthcare Organization; the South Dakota Department of Health; and the South Dakota Department of Social Services. The project's evaluator also meets monthly with the consortium to provide ongoing feedback throughout the grant period. "Every consortium member remained very involved throughout the course of the grant and without question that involvement was important to the outcome of the project," writes the project director. The consortium convenes its meetings over the telecommunications network because of the long distances between members.

The South Dakota Geriatric Forum is working to establish a non-profit entity that will continue to provide long-distance geriatrics education to health care professionals after the outreach grant expires. Programs will be broadcast on a subscription basis using the current telecommunications network and associated satellite system. Project staff will also apply for grants.

PROJECT **65**

COMMUNITY
HEALTH OUTREACH
Cherokee Health Systems,
Talbott, Tennessee

Contact:
Dennis S. Freeman, PhD,
Chief Executive Officer

Cherokee Health Systems
6350 West Andrew
Johnson Highway
Talbott, TN 37877
(423) 586-5031
(423) 586-0614 fax

This educational program in the heart of Appalachia teaches children, their parents, and educators how to stay healthy mentally and physically, and to access needed health services to attain this goal. Poverty, illiteracy, and limited physical and mental health services have created a health care crisis in the counties of Grainger, Union, and Claiborne. Many residents rely on TennCare (the state's new program that replaces Medicaid) or have no health insurance coverage. The educational program teaches individuals to take personal responsibility for their health. The project also works to improve the community's network of health services, so that individuals who are seeking care have access to services.

A team of outreach workers visits school sites, providing physical and mental health education, screenings, and referrals to all children in grades K-12. The team uses a number of innovative educational methods, including children's literature, drama, and interactive activities. Mental health screenings include those for body image/eating disorders, anxiety, depression, stress, anger, and codependency. Because many clients lack transportation to visit clinics, mental health clinicians provide counseling services in the schools. Project staff also conduct inservice training programs for teachers and parents, and provide teachers with mental health consultations regarding specific students.

As of May 1997, the project had made more than 37,000 educational contacts with children, and 2,000 contacts with parents and teachers through inservice trainings. Outreach workers had conducted more than 3,100 screenings, and mental health clinicians had provided 1,255 individual counseling sessions. Throughout the grant period, more than 30 health care professionals provided advice, programming, and services to support the project. School guidance counselors and principals also were essential by providing access and assisting with planning and implementing project activities.

Although the law provides for screening large groups or entire classes of youth without parental permission, the project found that requesting consent from parents and providing opportunities for parental education built trust within these communities. "Targeting children and their parents has strengthened and prolonged the impact of this project," writes the project coordinator. The project also participated in health fairs and gave presentations to groups as part of its community outreach efforts.

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COMMUNITY HEALTH OUTREACH

In addition to its educational component, the project also worked to improve the health services network in the three-county area. Clinical services increased during the grant period with the opening of two integrated care facilities in Grainger, and one in Claiborne. Services in Union County have been expanded by two medical practitioners, several clinicians, a dentist, and a dental hygienist.

One obstacle that continues to hinder families from accessing medical care is a lack of health insurance. "Individuals having to decide between feeding their families and participating in preventive care will make survival choices," writes the project coordinator. Other communities developing similar programs may find it beneficial to assess the health insurance status of its target population, and perhaps include a coverage component in its project.

The project's consortium is led by Cherokee Health Systems, a private, non-profit integrated care organization and the sole provider of mental health services in the three-county area. Union-Grainger Primary Care and Clinch Mountain Regional Health Center, the area's two primary care providers, contributed health education materials and gave presentations to children and adults. The three county school systems complete the consortium.

Most of the project's consulting and educational activities will continue after the grant period through support from consortium members. The expanded health care network will also continue serving this community. The consortium plans to open a Wellness Resource Center/Library, centrally located in one of the primary care clinics, which will house reading materials and audio-visual resources available for checkout. The Governor's Prevention Initiative may provide some additional funds.

PROJECT **66**

HOUSING HEALTH EDUCATION RURAL OUTREACH (HHERO) PROGRAM
LaFollette Housing Authority, LaFollette, Tennessee

Contact:
Helen Broyles,
Deputy Director

LaFollette
Housing Authority
P.O. Box 392
LaFollette, TN 37766
(423) 562-2261

The LaFollette Housing Authority implemented the HHERO program to provide health education and primary care services to the residents of public housing throughout a seven-county area in rural east Tennessee. A large percentage of the area's 4,000 public housing residents are single mothers with one or more children; another one-third are elderly. Ninety percent rely on TennCare (the state's new program that replaced Medicaid) for their health care services.

Before the project implemented any programs or services, it conducted a health risk assessment survey to determine the physical and psychosocial health needs of the families in public housing. As expected, health care needs differed somewhat between counties and housing development sites. Yet general findings indicated this population is at high risk for elevated cholesterol, elevated blood pressure, obesity, smoking, lack of seat belt use, lack of exercise, and low life satisfaction.

The health risk assessments were the first ever conducted on this rural population, writes the project director, and "they were crucial to gaining an in-depth understanding of the health needs and health risks of the housing development population." It was clear from the findings that interventions were needed regularly and on several different interactional levels: individual, group, and community. To meet these needs, the project implemented a plan for health interventions following national guidelines, and publicized these activities in a "Calendar of Events" distributed monthly to all residents. Interventions have included community-wide screenings for diabetes, vision, and dental health; mobile mammography; childhood immunizations; flu vaccines; nutrition assessments; and an eight-week parenting skills course.

The HHERO project also established a rural health clinic known as "Health Corners," staffed by a family nurse practitioner and an outreach nurse. The clinic is fully equipped to provide preventive and primary care, as well as basic laboratory tests. Over time, families started coming to the clinic not only for crisis care, but for preventive care. This was a major achievement for the program, for it signaled that families were learning to take more responsibility for their health care.

It took time, initially, to develop the trust of the housing residents. Rapport grew slowly as residents had positive experiences at the clinic and spread the word to neighbors and

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HOUSING HEALTH EDUCATION RURAL OUTREACH (HHERO) PROGRAM

friends. Other residents, however, remained cautious, concerned that the HHERO staff might perform drug testing or refer them to local authorities for child or elder neglect. A program such as this requires an intensive campaign of education and trust-building before families will actively seek preventive health care services, notes the project director.

Working in conjunction with the LaFollette Housing Authority are several dissimilar entities that have joined efforts to accomplish the consortium's goals. The University of Tennessee Regional Medical Center, a teaching hospital in Knoxville, provided the services of the nurse practitioner and outreach nurse, as well as lab tests and medical supplies. The Monroe Maternity Center, a rural birthing center, provided technical assistance and education for HHERO staff. The University of Tennessee Social Work Office of Research and Practice conducted the evaluation component of the program.

The project has had tremendous difficulty surviving under TennCare. The state made the transition in 1994, just as the outreach project was being implemented. Insurance providers recognized by the TennCare program do not reimburse for primary health care services provided by family nurse practitioners, even when they have physician supervision. Most of the project's clients have moved into the managed care system, and it has been difficult to find providers who will work with a clinic that is not part of that system.

The project attempted to contract with TennCare, yet was not accepted because TennCare was not granting any more contracts at the time. Had the project been able to contract with TennCare, it would have been paid $11 per patient per month in a capitation reimbursement system, regardless of how many times that patient visited the clinic. This amount would not have been enough to cover staff salaries.

The project attempted to arrange for a local entity to provide services out of the clinic, yet was unsuccessful. The Health Corners clinic will not continue after the outreach grant expires.

PROJECT **67**

MAKING
TENNCARE WORK
West Tennessee Community
Development Foundation,
McKenzie, Tennessee

Contacts:
Dr. Thomas J. Hamilton,
Executive Director

Tanya Irwin,
Project Director

West Tennessee Community
Development Foundation
Box 671
McKenzie, TN 38201
(901) 352-2393

Making TennCare Work was designed to provide individuals enrolled in Tennessee's new managed care program with assistance in overcoming problems resulting from the abrupt introduction of that program. The project also provides data to the state legislature, the TennCare Bureau, and advocacy groups to assist these bodies to permanently resolve TennCare-related problems, particularly those that adversely affect rural areas.

Tennessee initiated its TennCare program on January 1, 1994, a scant two months after receiving the necessary waiver from the federal Health Care Financing Administration (HCFA). On that date, more than 600,000 Medicaid beneficiaries living in Tennessee were disenrolled from Medicaid and simultaneously enrolled in one of eleven newly formed managed care organizations (MCOs) that were subsidized by capitation payments made by the TennCare Bureau. During the following year, the initial group of TennCare beneficiaries was expanded to include about 400,000 persons who could not obtain insurance in the workplace and about 200,000 individuals deemed uninsurable by commercial insurance companies. Thus, within one year, about 20 percent of the state's population had been enrolled in eleven organizations that had little or no experience in administering managed care. Understandably, problems were rampant. Furthermore, many of these problems were particularly prevalent in rural areas.

The project's service area is a microcosm of rural Tennessee. It consists of three counties in west Tennessee (Hardin, Decatur, Benton) whose population of 44,000 persons is comparable to the state's other 90 rural counties with respect to unemployment rates, income, morbidity factors, and rates of adolescent pregnancy. Thus, data from the service area can be extrapolated to the other rural areas of the state with a fair degree of confidence.

The project operates on both a micro and macro level. On the micro level, it provides education, advocacy and case management to TennCare beneficiaries residing in the project's service delivery area. For example, the project provides information about TennCare benefits to all TennCare eligible households in the service area that request such information. As of May 1997, 4,750 households (67 percent) had requested benefits information from the project. Project staff also assist beneficiaries living in the service area to resolve difficulties with either the TennCare Bureau or the MCOs to which they have been assigned. During

MAKING TENNCARE WORK

the course of the project, staff have assisted 4,572 households to overcome these types of difficulties. Finally, staff provide case management to TennCare beneficiaries who have chronic conditions such as asthma, diabetes, or hypertension so that these individuals receive the care to which they are entitled. As of May 1997, 5,122 TennCare beneficiaries residing in the service area have received this type of assistance.

On the macro level, the project aggregates data derived from individual-level activities and provides it to those bodies making policy and operational decisions, in hopes of achieving effective and efficient delivery of TennCare services in the state's rural areas. For example, the project compiled and disseminated case studies of more than one hundred beneficiaries who had been adversely affected by TennCare Bureau policies. These problems included termination of benefits, pharmacists' disregard of bureau regulations, reductions of premiums due to seasonal work, and MCO failure to establish appropriate provider networks or to approve services of out-of-network providers. The project placed particular emphasis on the problems that are more severe in rural than in urban areas. These studies were presented to the Legislative Oversight Committee of TennCare. After examining them, the committee directed that the TennCare Bureau work with the West Tennessee Community Development Foundation, the project's lead agency, to devise policies that would eliminate the problems. By March 1997, most of the problems had been resolved.

The project also conducted two statistically valid surveys of beneficiaries' attitudes toward the TennCare subsidized MCOs to which they belong. Data from these surveys were used in two ways. If a household reported difficulties with its MCO, staff attempted to work with the MCO to adjudicate the problem. Staff also used aggregate data from the surveys to compile reports on each MCO operating in the project service area, and shared these reports with the TennCare Bureau and all service area beneficiary households. The Bureau used them to effect improvements in the operations of some MCOs. The beneficiaries used the reports to support requests for changes in the MCOs to which they were assigned.

Finally, a survey of provider attitudes toward the MCOs operating in the project service area has yielded insights that have enabled some of these organizations to expand their provider networks. The expansion has given individual beneficiaries a greater

choice of providers and has strengthened the membership base of those MCOs committed to providing the quality of care envisioned in the original design of TennCare.

The most significant lesson learned from these surveys, writes the project director, is that "policy makers will question and often reject anecdotal evidence, but will respond to data that are statistically and empirically valid."

All consortium members work together to devise strategies to overcome problems affecting residents of the service area and, more importantly, to influence policies that will result in the elimination of problems on a statewide level. The West Tennessee Community Development Foundation, a private, non-profit foundation, collaborates with Hardin County General Hospital, which provides information about Tenn Care-related problems confronting rural hospitals. Southwest Tennessee Head Start Program provides insights into the problems affecting families with incomes at 200 percent or less above the federal poverty level. Homecare, a local home health agency, provides information concerning the problems affecting the elderly enrolled in the program.

The project will continue to provide education, advocacy, and case management to its service area, which was expanded in September 1997 to include two more west Tennessee counties: McNairy and Henderson. The continuation and expansion of project services will be funded by the United Way, the West Tennessee Community Development Foundation, and one of the TennCare affiliated MCOs.

Call For Health is a national, bilingual, toll-free health information and referral resource created for the nation's four million migrant and seasonal farmworkers and their dependents. Harsh working conditions and substandard living arrangements frequently compromise farmworker health. Some of their health problems, such as infection from water-borne parasites due to lack of potable water, are commonly found in Third World nations. Farmworkers are thought to have the highest infectious disease rate in the nation. Yet they are excluded from health care services by barriers of language, lack of money, low literacy, lack of sick leave, and lack of knowledge about where to seek help.

Call For Health is the first ever national resource for farmworkers in need of health care information and referral. The toll-free line can be reached from any location in the United States and Puerto Rico. Callers are provided referrals to affordable sources of care; assistance in overcoming bureaucratic barriers to obtaining care; translations; and directions or referrals to other agencies for non-health related problems.

If at all possible, farmworkers in need of health care services are referred to a migrant health center. These facilities are designed to accommodate the special bilingual, bicultural needs of farmworkers. They also provide services outside of traditional office hours so that farmworkers can seek care without forfeiting a day's wages. If the caller is not near a migrant health center, staff members seek other sources of care, drawing upon the program's resource library and database of organizations and agencies that serve farmworkers. These entities include clinics, private providers, churches, food banks, and local assistance organizations.

The project has succeeded in providing an extraordinary level of service to callers in need of affordable or donated health care services. As of May 1997, the project had received 1,005 calls for health information or referral. This number is lower then originally anticipated. However, the level of need on the part of callers and the quality of service provided are high.

In conjunction with this project, the National Center for Farmworker Health (the project's lead agency) has created the Friends of Farmworker Families Fund to help farmworker families obtain needed health care services if no affordable assistance can be located through the Call For Health service.

CALL FOR HEALTH
National Center for
Farmworker Health,
Austin, Texas

Contacts:
E. Roberta Ryder,
Executive Director

Joni Barnett,
Director of Health
Center Services

Gina R. Lombardi,
Public Information
Coordinator and
Project Supervisor

1515 Capital of Texas
Highway South
Suite 220
Austin, TX 78746
(512) 328-7682

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CALL FOR HEALTH

Because many farmworkers do not have access to simple preventive health care information, the project has developed a bilingual, low literacy health education newsletter for farmworkers called Farmworker News. The newsletter is published every other month and is distributed nationally to farmworkers through migrant health centers and other organizations working on behalf of farmworkers. More than 111,000 copies of the newsletter had been distributed as of May 1997.

The project has also trained four farmworker peer educators (consejeras) who disseminate vital heath information in the farmworker communities as well as promote awareness of the Call For Health toll-free line. Each consejera works in conjunction with one of the three migrant health centers that participate in the project's consortium. As of May 1997, the consejeras had made more than 23,000 health education contacts.

The project's consortium is composed of the National Center for Farmworker Health, based in Austin, Texas and the three migrant health centers — Gateway Community Health, United Medical Centers, and Clinica Familiar de Salud Le Fe. These organizations have participated very actively in the training and supervision of the consejeras.

In addition to the core consortium, the project has a larger group of program participants who have signed Memoranda of Agreement (MOAs) to support project activities. The National Center for Farmworker Health provides program participants with information, promotional materials, and the Farmworker News. Program participants agree to distribute information and materials to their farmworker clients and to promote the toll-free service. They also provide information about local resources available to farmworkers for inclusion in the project's health information and referral library and database. To date, more than 130 program participants have signed MOAs with Call For Health. They include migrant and community health centers, health departments, school districts, Head Start agencies, and farmworker advocacy organizations.

The most significant problem encountered in the project has been generating farmworker awareness of the toll-free line. It has been very difficult, given the size of the project's budget, to carry out a traditional national advertising campaign. Successful local promotion strategies have included mailing public service announcements to Spanish language radio stations, and issuing press releases to Spanish language newspapers. In 1996, the

project produced a pocket directory of migrant health centers, and revised it in 1997 to include migrant education service sites. More than 93,000 directories have been distributed.

Another challenge has been garnering trust with the patient population. Notes the project supervisor, "Bitter experience has made the farmworker population leery of harassment, disrespect, and questions regarding legal status. It is fundamental to convince farmworkers that it is safe to approach [this] program to request help."

In the short term, the project plans to continue the Call For Health toll-free service with the support of the Migrant Health Branch of the Bureau of Primary Health Care. Eventually, staff hope that the project's budget will be incorporated into the base grant funding of the National Center for Farmworker Health. During the grant period, the consejera activities were jointly funded by the Outreach Grant and by the Centers for Disease Control and Prevention (CDC). Staff hope that the CDC will continue to support the consejera activities. The project is also seeking funding from other federal agencies and private foundations for the continued support of the Farmworker News, Call For Health promotional materials, and the Friends of Farmworker Families Fund.

A county hospital, a state department of health, and a Fortune 500 corporation have joined forces through this outreach project to provide much needed prenatal care to a growing immigrant population in central Texas. The economic growth of Pilgrim's Pride Industries, a chicken processing plant in Mt. Pleasant, Texas, has attracted a large number of immigrants to this area an hour from Dallas. Most of these individuals lack access to local health care providers and are ineligible for Medicaid coverage.

The project has established a prenatal clinic to serve uninsured and underinsured Hispanic women in five counties. Case management and family planning services have been added over time. Spanish providers and translators are used whenever possible, and all educational materials, forms and applications, videos, and classes are offered in Spanish. The project also assists clients in obtaining existing social services, such as the WIC nutritional program.

As of May, 1997, the clinic had provided prenatal care services free of charge to 728 women, and provided education classes and health promotion information to 2,020 individuals. More than 70 women visit the clinic each month for annual family planning visits. The clinic targets its services to women who are not covered by Medicaid (although they can receive emergency Medicaid at the time of their delivery). Women who are covered by Medicaid are referred to providers in town who see Medicaid patients.

An important indication of the clinic's success is that Titus County Memorial Hospital is no longer seeing women presenting for delivery as "walk ins" in the emergency room. Also, data from the Texas Deparrment of Health show that out-of-hospital births (almost all of which were attended by untrained lay midwives) have dropped from 8.5% to 2% in Titus County. The clinic has become firmly established in the community, and local physicians, initially unsure of the clinic's potential, have spoken highly of the effect the clinic has had on local obstetric care.

The outreach grant has also subsidized the education of a certified nurse midwife, covering her tuition, travel, and book costs. This individual will graduate from the Frontier School of Nurse Midwifery (another rural outreach grantee) in August 1997, and from that point on will provide prenatal, delivery, and family planning services for local underserved women.

PRENATAL CARE PROJECT: CUIDADO PRENATAL

Titus County Memorial Hospital District,
Mt. Pleasant, Texas

Contacts:
Martha Deming, RNC,
Grant Director

Anne Larkin Tom,
Grants Manager

Titus County Memorial Hospital District
2001 North Jefferson
Mt. Pleasant, TX 75455
(903) 524-4700
(903) 524-4900 fax

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PRENATAL CARE PROJECT: CUIDADO PRENATAL

The most significant problem encountered by the project was the weak continuity of care provided by the clinic. The clinic was open Monday through Friday, 8am-5pm. If clients experienced pregnancy-related problems outside these hours, they were forced to rely on emergency rooms. This led to some dissatisfaction on the part of local obstetricians (who are on call for seeing these patients after hours) and who felt these patients did not have good continuity of care.

The project plans to address this problem in the future by using state funds to subcontract with area OB-GYN physicians. These physicians will provide prenatal care, including emergency consultations, to individual patients assigned to them for the course of their pregnancies. The clinic will also have a certified nurse midwife who will follow her patients throughout the course of care. "Anyone attempting to duplicate our program would be wise to address the problem of continuity of care up front," writes the project director.

One of the most important factors in this project's success has been its partnership with the Texas Department of Health, a consortium member. For several years, the state of Texas has been shifting toward contracting with local providers for primary and preventive care services. The success of the outreach prenatal clinic has placed the project in a strong position to take over other public health services, such as family planning. As this shift has occurred, the Texas Department of Health has given the project a great deal of support, both in terms of assistance from staff, and in funding. Specifically, state Maternal Child Health funds and services have been made available; providers have access to the state laboratory system for the processing of prenatal lab work and pap smears; and sonograms are billed to the state. This support has made a tremendous difference to the project, as the costs of labwork alone would have required a large proportion of the budget.

The Prenatal Care Project will continue to provide services after the outreach grant expires through state funding and continued support from Pilgrim's Pride Industries. Titus County Memorial Hospital will also continue to aid the project with the provision of a facility and support services. The project will also explore other funding sources such as Medicaid billing and private pay.

PROJECT **70**

RURAL EMERGENCY EDUCATION NETWORK TELECOMMUNICATIONS (REENT)
Stephen F. Austin State University, Lufkin, Texas

Contacts:
Linda Whiting, MBA
Piney Woods AHEC Director and Project Co-Director
Stephen F. Austin State University
Piney Woods Area Health Education Center
1118 West Frank Avenue
Lufkin, TX 75904
(409) 639-7823

Karen Hand, MSN, RN, CNS, CEN
Assistant Professor and Project Co-Director
Department of Adult Health Nursing
University of Texas Medical Branch at Galveston
Galveston, TX 77555-1029
(409) 772-1184

The Rural Emergency Education Network Telecommunications (REENT) project uses distance learning technology to provide monthly continuing education (CE) programs for rural emergency providers in 59 East Texas counties. Before this outreach project, continuing education related to emergency care had been sporadic in the region. The gap was particularly severe for emergency medical technicians, and was a major contributing factor behind the profession's high turnover rate. Although rural physicians and nurses have more CE opportunities, they were also finding it difficult to receive trauma-related training that was relevant to their region's capabilities.

Among the project's most innovative aspects is its combination of distance learning and on-site instruction to deliver CE. During a typical four-hour session, participants receive 1.5 hours of live instruction from an urban medical center using a satellite downlink; 1 hour of videotaped materials (skill demonstrations and scenarios); and 1.5 hours of hands-on instruction. The use of mixed media gives participants the advantage of instructors from urban areas combined with local trainers who are well-versed in rural issues. Participants also can interact with the urban instructors through a toll-free number.

The project has gone to great lengths to incorporate the reality of rural health care into its curriculum. Local emergency medical services (EMS) organizations, fire departments, and health care providers have worked hand in hand with urban health care professionals to design a relevant curriculum and assist with instruction and equipment.

As of May 1997, the project had produced 25 continuing education programs, ranging in length from 4 to 12 hours, with three more in development. Nineteen sites have received 1 to 23 of these programs, for a total of 147 programs. Topics include trauma, general medical emergencies, obstetrics, violence and drug use, agricultural injuries, ethics, pediatric and geriatric issues, head injury, cardiovascular incidents, and disaster management. Training materials that accompany these programs have been distributed to 50 individual providers, six EMS/volunteer fire departments, and other allied health educators and health care organizations.

Through May 1997, the CE programs had attracted 1,926 attendees (811 individuals) for a total of 8,550 credit hours earned. More than half of those attending are emergency

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RURAL EMERGENCY EDUCATION NETWORK TELECOMMUNICATIONS (REENT)

medical technicians (EMTs), while most of the remainder are nurses. The balance includes physicians, physician assistants, nurse practitioners, certified nurse midwives, other allied health professionals, students (medical, nursing, and EMT), and foster parents.

Local schools, hospitals, and businesses have contributed facilities for the CE sessions, and the project has gradually added sites during the grant period. By May 1997, it was transmitting monthly programs to 13 regular sites, serving providers in 59 counties. The Piney Woods Area Health Education Center (AHEC), the project's lead agency, handles registration, equipment acquisition, instructor recruitment, and on-site facilitation at eight of these locations. Other community colleges and AHECs handle these arrangements at the other five sites. The project also repeats programs upon request to regular sites and to other rural communities that may not have satellite access.

Technical problems proved the most difficult challenge initially. "Satellite downlink technology over the period of the project has been often unreliable, always expensive, and seldom interactive," writes the project director. The satellite link failed on many occasions due to problems with the transmitter, the receivers, or because the CE program was bumped for other programming. The technology's biggest drawback, continues the project director, is its limited capacity for interactive participation, as the toll-free number can only be used by one site at a time. Participants are also often reluctant to call in with questions.

To address these problems, the project increased its use of taped materials; improved the preparation of its on-site instructors so that the program could continue if the satellite portion was unavailable; and encouraged on-site instructors to make calls for participants. All of these solutions have proven satisfactory, writes the project director. Still, "satellite technology is a poor medium for distance learning if interaction is desired." She notes that interactive televideo (ITV), which uses telephone lines to transmit the signal, is much more conducive to this purpose. The technology is just now gaining a foothold in east Texas.

Another challenge was the development of a relevant curriculum. The initial curriculum, designed by the University of Texas Medical Branch, was too academic and sophisticated for program

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participants. Regional consortium partners were added to assist in restructuring the curriculum to meet rural needs and concerns. The project also added videotaped scenarios of rural medical emergencies to the programs. These scenarios include a mock disaster at a paper mill, a motor vehicle accident, a logging injury, and an accidental shooting, all of which were filmed in the east Texas area.

Leading the project's consortium is the Piney Woods Area Health Education Center,'a health education and training outreach department of Stephen F. Austin State University. Completing the original consortium is the University of Texas Medical Branch at Galveston; the University of Texas Health Science Center at Houston; and the Council of the Advancement of Rural Education, a community-based organization. Several other agencies were added during the grant period to assist with curriculum design and program delivery. These include several community colleges (Angelina College, Northeast Texas Community College, and Paris Junior College), the Texas Department of Health, and two other area health education centers (Pecan Valley AHEC and Rose Country AHEC).

Several consortium partners plan to continue offering emergency care CE in their communities using the curriculum and training materials developed for this project. None of these projects will incorporate the use of distance learning technology, however. The Piney Woods Area Health Education Center is currently planning separate continuing medical education series for physicians and mid-level providers using interactive televideo. The consortium is also seeking funding to create an interactive televideo network to provide community health education in rural areas.

PROJECT **71**

RURAL HEALTH OUTREACH DEMONSTRATION PROGRAM

Primary Care Services, Inc.
Terlingua, Texas

Contacts:
Jennifer Hogue,
Project Coordinator
(915) 371-2661

Sarah Bourbon,
President
(915) 371-2202

Primary Care Services, Inc.
P.O. Box 200
Terlingua, TX 79852

An isolated Texas community near the Mexican border has made widespread improvements in its rural health clinic, emergency medical systems, and fire department. The Big Bend Family Health Center, located in Terlingua, plays a pivotal role in the region's health care, as it is the sole provider of primary care within 80 miles. The clinic serves not only the area's 2,000 full-time residents, but also the more than 300,000 individuals who visit the adjacent Big Bend National Park annually. All roads leading out of this region are winding and mountainous, making travel treacherous.

The Big Bend Family Health Center is a non-profit rural health clinic staffed by a full-time physician's assistant and a patient care technician. It is operated by the Big Bend Regional Medical Center, located 80 miles away in Alpine. In addition to primary care, the clinic provides a base of operation for many social service agencies, including the Texas Department of Health and Human Services, the Texas Department of Mental Health and Mental Retardation, Aliviane (a drug and alcohol counseling agency), and Adventures in Parenting classes. Just over half of the area's residents are Hispanic, and 85 percent meet federal poverty level guidelines.

The outreach grant provided for the salaries of the clinic's physician's assistant, patient care technician, and office manager during the grant period. It also purchased important laboratory equipment for the clinic and a much-needed water pump and water storage tank to replace an unreliable well. Three health fairs sponsored by the consortium drew about 120 participants.

The project also provided necessary equipment and training to upgrade the area's urgent care systems. The Terlingua Medics (consisting of one paramedic and one emergency medical technician) received training in advanced cardiac life support and purchased a new computer system for billing and record keeping. The South Brewster Responders, a group of volunteer emergency care attendants and emergency medical technicians, trained five individuals as emergency medical technicians and purchased automatic defibrillators and other equipment. In addition, the Terlingua Area Volunteer Fire Department purchased new equipment for the fire truck.

To improve patient access to specialized medicine, the project installed a telemedicine system that allows for real-time audio-visual consultations with specialists at the Texas Tech

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RURAL HEALTH OUTREACH DEMONSTRATION PROGRAM

University Health Science Center, 400 miles away in Lubbock, and at Sul Ross State University, 80 miles away in Alpine. The unit has been used very little, however. The project director suspects that this is because patients do not want to establish a relationship with a specialist in Lubbock, which might require them to drive 400 miles, when they can see one in Midland-Odessa, "only" 250 miles to the northeast, or El Paso, 300 miles to the northwest. Instead of medical consultations, the telemedicine unit is more commonly used for linking distant consortium members for meetings.

Leading the project's consortium is Primary Care Services, Inc., a non-profit advisory board that operates the Terlingua clinic for the Big Bend Regional Medical Center in Alpine. Other consortium members are the Big Bend Family Health Center, the Big Bend Regional Medical Center, Terlingua Medics, Terlingua Area Volunteer Fire Department, South Brewster Responders, Terlingua and San Viciente school districts, Texas Tech University Health Science Center, and the Texas Department of Health.

The Big Bend Regional Medical Center was recently purchased by Community Health Systems, a for-profit health care organization. The organization will keep the Terlingua clinic open four days per week as well as pay its operating expenses and any revenue shortfall. The consortium has also conducted several successful fundraising activities, including a wild game cookout and a "carbo load" dinner before the Chihuahuan Desert Challenge Mountain Bike Festival.

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RURAL HEALTH OUTREACH DEMONSTRATION PROJECT

Jasper Newton County Public Health District, Jasper, Texas

Contacts:
Frances Simmons, RNC, MEd, Assistant Director

Melvin R. Bottorff, MD, FACOG, Medical Director

Jasper Newton County Public Health District
139 West Lamar Street
Jasper, TX 75951
(409) 384-6829
(409) 384-7861 fax

Throughout four counties in east Texas, a community-based network of trained volunteers gives presentations in minority churches to increase awareness of available health and social services. The project was designed after meetings between the Jasper Newton County Public Health District and leaders in the African American and Hispanic communities. Through these discussions, it was determined that individuals were not receiving medical care because they were unaware of available health care resources; they lacked transportation; and when they did access the system, they could not afford to pay for medications.

The church presentations cover health promotion and disease prevention, and identify health and social services available in the community. Individuals needing services such as immunizations, family planning, prenatal and well child care, and the WIC nutritional program are referred to the health department, the project's lead agency. Individuals who require primary care services, but who do not have a physician, are referred to the Deep East Texas Rural Health Center, a community health center and a consortium member.

Project volunteers also provide eligibility screening to identify individuals whose incomes are low enough to qualify them for health and social service assistance. For these individuals, grant funds are used to assist with prescription medications, dentures, and eyeglasses. The project also provides transportation to health and social services when needed.

Other innovative outreach efforts have included health education programs, in the form of puppet shows, presented to children at summer food projects. The project also has published and distributed a resource guide of available services in the four-county area. Overseeing the volunteer program and all other project activities is a full-time staff of four.

As of May 1997, the project's outreach and educational activities had reached 5,579 individuals. The project helped 2,591 individuals receive prescription medications, 60 to receive dentures, and 51 to receive eyeglasses. More than 900 received transportation services.

The Jasper Newton County Public Health District, the Deep East Texas Regional Health Center, and the Deep East Texas Council of Government's Area Agency on Aging formed the project's consortium. The consortium arrangement proved to be

RURAL HEALTH OUTREACH DEMONSTRATION PROJECT

of great benefit to the agencies involved, writes the project director. Members learned of the services available through other agencies, and they accomplished far more through working together than they would have alone. The consortium also invited other local health care and social service providers to their meetings to identify needs and discuss solutions.

Project staff feel that this kind of project would work well in other rural areas. Ministers and leaders of small rural churches are typically willing to address the health care needs of their communities. "With leadership, funds, and direction, rural communities can use volunteers to increase public awareness of health promotion and disease prevention," writes the project director.

Members of the consortium will continue to work together after the outreach grant expires, directing their efforts toward expanding pharmaceutical assistance programs and addressing gaps in primary care and transportation services. The consortium has applied for new funding from public and private agencies to address these needs. The volunteer network will also continue its outreach and education efforts.

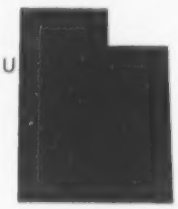
A network of volunteers spread across a 17,500 square mile area of southwestern Utah provides transportation to medical appointments through this outreach project. A 1991 survey identified this need as the most critical concern of rural senior citizens in the region. In fact, many were at risk of losing their independence because of this issue. The four counties that make up the service area include parts of the Ute and Navajo reservations. The area has no public transportation other than Amtrak and Greyhound Bus, which make only late evening and midnight stops.

The Care-A-Van program provides door-to-door service to medical appointments for seniors, individuals with disabilities, and others with chronic health conditions who cannot drive themselves. Volunteer drivers are trained in first aid, CPR, defensive driving, and inhalation therapy (oxygen tank safety). They are also equipped with cellular phones and pagers so that they are accessible to clients and health care providers. Volunteer drivers provide their own vehicles and purchase their own gasoline and insurance coverage, with reimbursement from the program at 28 cents per mile. When transporting a disabled person unable to transfer from a wheelchair, drivers use a donated van equipped with handicap accessories.

The project provides transportation to local medical appointments as well as to distant medical facilities in Salt Lake City; Provo; Durango, Colorado; and Grand Junction, Colorado. In some cases, these trips can take up to 10 hours and cover 500 miles round trip. To cover these great distances, the project makes arrangements for volunteers to drive in shifts, so that one volunteer drives the client to the next town, where another volunteer takes over and drives to the next town, and so forth.

As of May 1997, 20 volunteers have helped 130 clients make 500 trips for medical appointments. These trips total 56,371 miles and 2,156 donated hours. Most clients are low-income, homebound individuals.

The Southeast Utah Area Agency on Aging, located in Price, manages the project and promotes it at the state, county, and local level. Its consortium partners are the Easter Seal Society in Salt Lake City, which provides suggestions concerning volunteer recruitment, legal status and training; and the Southeastern Utah District Health Department, also in Price, which refers many clients to the program.



CARE-A-VAN
Southeast Utah
Area Agency on Aging,
Price, Utah

Contacts:
Maughan Guymon,
Director

Anna Prawl,
Program Manager

Southeast Utah Area
Agency on Aging
375 South Carbon Avenue
P.O. Box 1106
Price, UT 84501
(800) 250-4022

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CARE-A-VAN

Probably the most important lesson learned through the project's evaluation is the importance of keeping public officials informed of the program's progress. The project now mails a monthly newsletter to state agencies and public officials to maintain the program's visibility with people who determine budget allocations.

The project has also learned a great deal about recruiting and retaining volunteers. The recruitment process must be ongoing in a volunteer-based program such as this. The project advertises its services and recruits volunteers through brochures, spot features on radio and television, classified ads, presentations to senior citizen and veterans groups, and letters to churches and community organizations. While many potential volunteers have a strong sense of service to others, it is essential that they be reimbursed for their gasoline expenses if they are to remain volunteers for long.

The Care-A-Van project achieved self-sufficiency in February 1996 and will continue to provide transportation services after the grant period. The project has asked all health and social service agencies whose clients use the Care-A-Van program to reimburse the project at the mileage rate when clients use the service. The project has secured mileage reimbursement contracts with the Southeastern Utah District Health Department; the Utah Department of Health Care Financing; the Disabled American Veterans and other private organizations. The Agency on Aging will assist with administrative costs, and other grant applications and fundraising efforts are planned for this purpose as well.

A small community in northeast Vermont has established a Youth Wellness Center to provide much needed mental health services to low-income, troubled adolescents. Since its inception, the center has provided direct services to nearly 500 teens; many have experienced domestic violence, substance abuse, physical abuse, and sexual abuse. Some are living in foster care, in other substitute care, or living independently. The purpose of the Youth Wellness Center is to make existing mental health services more accessible to teens, and to augment these services when necessary. The project serves youth ages 13-21 living in Caledonia County and southern Essex County.

The Youth Wellness Center provides an array of mental health services, including individual and family counseling; support groups dealing with anger management, women's issues, and substance abuse; teen parenting services; counseling as an alternative to school suspension. It also provides a safe venue for supervised visitations.

As of May 1997, the project had provided individual and family counseling to nearly 500 youth, and more than 250 had participated in the project's 30 support groups. Twelve individuals had participated in program activities as an alternative to school suspension.

The project has also implemented a successful peer education program. Together with Umbrella, a women's advocacy group, the project has trained 50 youth to give presentations at local schools on topics such as harassment, health risk behaviors, and other issues of concern to teens. The teen educators use skits, panel discussions, and small group discussions to reach their peers. About 2,000 students have participated in these educational programs.

During its first two years, the project also sponsored an annual wellness fair. Students and staff from area schools were invited to attend, and more than 30 area organizations participated. The events were a huge success, with about 800 people attending the first year and 1,200-1,500 attending the second year.

Twenty-six local youth-serving organizations make up the project's consortium, including 10 primary care and public health health care providers, five schools, two youth services agencies, two social service agencies, an alcohol and drug abuse program, and a mental health agency. The sheer size of the

YOUTH WELLNESS CENTER
Northern Counties Health Care, Inc.,
St. Johnsbury, Vermont

Contact:
Bonnie Griffin, RN, PNP,
Project Director

Youth Wellness Center
Box 146
St. Johnsbury, VT 05819
(802) 748-1128

Northern Counties Health Care, Inc.
18 Western Avenue
St. Johnsbury, VT 05819

YOUTH WELLNESS CENTER

consortium presented a problem, and it did not function as anticipated. Attendance at meetings was sporadic, some members saw the project as a threat, and other organizations ceased to exist or discontinued their youth services.

A handful of consortium members make up an active core, however. Northern Counties Health Care, Inc. serves as the project's lead agency. The Vermont Department of Health, Northeast Kingdom Mental Health, and Social and Rehabilitation Services conduct project planning. Northeast Kingdom Youth Services and Umbrella provide project services.

All project activities are expected to continue after the grant period. Recently, the Youth Wellness Center was designated a Federally Qualified Health Center, which will significantly enhance its ability to receive reimbursement for services after the outreach grant expires. The center also has hired a pediatric nurse practitioner to provide primary care services, which are also reimbursable. The consortium expects additional support from grants.

APPAL-LINK: THE SOUTHWESTERN VIRGINIA TELEPSYCHIATRY PROJECT

Cumberland Mountain Community Services Board, Cedar Bluff, Virginia

Contact:
Henry A. Smith, LCSW, Director of Mental Health Services

Cumberland Mountain Community Services Board
P.O. Box 810
Cedar Bluff, VA 24609

A state psychiatric hospital in southwestern Virginia is using interactive video teleconferencing to provide medication management to rural patients at seven remote outpatient facilities. Staff psychiatrists at Southwestern Virginia Mental Health Institute use the technology to provide follow-up care to mentally ill patients who have been treated in the hospital and then discharged into the care of the community service board in their community.

Patients treated through the Appal-Link Network have chronic and severe mental illnesses, including major depressive disorder, schizophrenia, bipolar disorder, and schizoaffective disorder. The network provides an opportunity for these patients to remain in their communities while still receiving long-term medication management from the same psychiatrist. The project also uses the network for treatment planning conferences, discharge planning, family visits, and commitment hearings. Generally, the hospital treatment team and a case manager from the local community service board conduct a discharge planning conference with the patient over the network to introduce all the participants to the technology.

The Appal-Link Network serves the poorest and most rural section of Virginia. A shortage of psychiatrists (only one per 16,000 people) has contributed to a high relapse rate for chronically mentally ill patients residing here. Before this project began, the region had the highest hospitalization rate in the state.

The project's use of teleconferencing has introduced "connectivity and continuity" into the state's public mental health treatment system, writes the project director. For the first time, providers at outpatient treatment programs have merged with the inpatient staff, resulting in a true continuum of care. Equally unique in this region, he writes, the technology allows long-term medication management oversight to be provided by the same psychiatrist. "This continuity of care simply has not occurred before within the public mental health treatment system in Virginia. From a fragmented and bifurcated system we have moved to a united and single orientation to mental health care," he writes.

The project began providing direct services over the Appal-Link network in February 1995. The network originally consisted of the state hospital and two community service boards serving four counties. Over the grant period, it has expanded to seven sites serving 17 counties. An eighth site, Blue Ridge Community Services Board, provides interpreting and counseling services to

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APPAL-LINK: THE SOUTHWESTERN VIRGINIA TELEPSYCHIATRY PROJECT

the deaf and hearing impaired throughout the region. The ninth site to join the network, the Southwest Virginia Alcohol Treatment Program in Lebanon, also serves the entire region.

By May 1997, consortium members had conducted 1,023 medication management appointments over the Appal-Link Network, as well as 357 case conferences addressing treatment plans, 60 family visits, 42 commitment hearings, and two forensic evaluations. The telepsychiatry clinic currently follows 83 patients.

Several evaluations of the project have revealed a dramatic decrease in hospital admissions for patients receiving regular medication management through the network. In reviewing these studies, it is clear that "providing the chronic severely mentally ill patient with access to follow-up care can make a difference in the patient's ability to remain in his/her own community, thereby helping to reduce long and costly hospitalizations," writes the project director.

The project's most significant problem has been the high cost of the network transmission over long distance telephone lines. "It is unfortunate," notes the project director, "that rural areas most likely to benefit from these emerging technologies are those most restricted by excessive cost. The cost has decreased somewhat during the grant period due to more competition, the introduction of ISDN technology into the region, and efforts made by federal and state agencies to level the playing field." The project has also discovered that transmitting at the relatively slow rate of 384 kbs is adequate for psychiatry, and provides additional savings.

A second significant problem encountered early on was a resistance to using the equipment by some outpatient staff. "We thought that there might be resistance from patients, but that was not the case," writes the project director. "The patients overall thought the whole experience to be satisfactory and fun, while the staff had to be convinced that this new technology was worthwhile." It took six months to one year before staff at the new sites became comfortable enough with the technology to use it effectively and frequently. The consortium assembled a training team from the earlier and more experienced sites to orient and train new sites as they joined the network.

The original consortium had four members: Southwestern Virginia Mental Health Institute, Cumberland Mountain

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APPAL-LINK: THE SOUTHWESTERN VIRGINIA TELEPSYCHIATRY PROJECT

Community Services Board (the grant administrator), Dickenson County Community Services Board, and New River Valley Community Services Board. The consortium has grown to include four additional community services boards, and the Southwest Virginia Alcohol Treatment Program. The demonstration project "has brought these organizations much more closely together as a regional working system with a resulting improvement in our services," writes the project director. "This new collaboration is an even greater outcome than the application of new technology."

In summarizing the project, the director writes that "communication technologies do and will continue to make a difference in the ways in which we provide health care. By way of this technology, components of fragmented care systems can be merged, and we can move toward maintaining the long-term mentally ill in their own communities. We will soon have psychiatric hospitals without walls."

All current sites, applications, and activities will continue after grant funding expires. Support is expected to come through a combination of direct state funding from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, local community services boards, and Medicaid billing (for medication management). If the project's request for state support is not fully funded, all eight community service boards have committed to providing funds to maintain the project.

PROJECT **76**

REACHING OUT TO LINCOLN COUNTY RESIDENTS

Lincoln County Public Hospital District No. 1, Odessa, Washington

Contacts:
Carol A. Schott, Administrator
Lincoln County Public Hospital District No.1
P.O. Box 368
502 East Amende Drive
Odessa, WA 99159-0368
(509) 982-2611
(509) 982-2616 fax

Tom Martin, Administrator
Lincoln County Public Hospital District No. 3
(509) 725-7101

Two public hospital districts, a county public health department, and a county counseling center are pooling their resources to improve access to health care services for residents living in isolated regions of Lincoln County, Washington. The county is a vast, sparsely populated area covering 2,300 square miles. It has no public transportation system, and travel is often hazardous due to severe winters, dust storms, and trucks and farm equipment on the roads. Transportation to health care is particularly difficult for elderly and low-income individuals, and for seasonal migrant farmworkers who work in the area from early spring to late August.

The consortium has developed two programs to address these barriers. First, it uses two handicap-accessible vans to provide transportation to health care appointments for those who need it. Second, it uses a mobile clinic to deliver health care services to remote parts of the county.

The transportation vans operate out of Odessa and Davenport, and have provided transportation to 700 passengers during the grant period. Citizens can schedule rides to and from providers. The project also uses the vans to transport residents to various screening programs and immunization clinics. Occasionally, they also take nursing home residents on outings to local swimming pools and other physical activity opportunities.

The project's mobile unit visits every remote community in Lincoln County on a rotating schedule. Physicians, dentists, and public health nurses — provided by consortium members — offer services on board, including cardiovascular health screenings, WIC program outreach, well child clinics, immunizations, dental services including restorative care, sports physicals, cervical and breast cancer screenings, mental health counseling, and nutrition education. A quarterly newsletter mailed to every county postal box announces mobile clinic schedules and other health care activities. As of May 1997, the mobile clinic had provided services to 1,600 individuals, roughly 17% of the county's population. Almost 400 had received dental care.

In addition to the newsletter, the consortium uses news articles, advertisements in local weekly newspapers, flyers and posters to announce project activities. It has initiated a toll-free line for health care information and referrals.

Leading the project's consortium is the Lincoln County Public Hospital District No. 1, located in Odessa. Its other consortium

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PROJECT **76**

REACHING OUT TO LINCOLN COUNTY RESIDENTS

partners, all in Davenport, include the Lincoln County Public Hospital District No. 3, the Lincoln County Pubic Health Department, and the Lincoln County Counseling Center. The project has also formed two committees that guide the consortium. The first is composed of health care providers and agencies in the county. The second involves citizens, business people, and school officials.

The two public hospital districts and the public health department have formed a new public entity called the Lincoln County Public Health Coalition, overseen by the Lincoln County Commissioners. The formation of this entity involves an integration of services among its participants, and creates a new financial and business management structure in the county's public health system. In 1995, the new coalition was named a Community Care Network recipient from the W. F. Kellogg program through the American Hospital Association. The accompanying grant will continue through December 1998.

The mobile clinic, transportation service, and toll-free information line will continue after the grant period. The coalition is also expanding some project activities into neighboring Grant County. All activities are supported with in-kind and matching funds from the two public hospital districts, state funding of mandated programs such as WIC, county allowances, fees for services, the Kellogg grant, and contributions from churches, businesses, and other community groups.

PROJECT 77

WEST VIRGINIA CHILDREN'S HEALTH PROJECT
Harts Health Center,
Harts, West Virginia

Contacts:
Steven L. Shattls,
Executive Director

Ken Stone,
Project Coordinator

Harts Health Center
4 State Route 10
Harts, WV 25524
(304) 525-3334

Families living in the rugged, geographically isolated hollows of southwestern West Virginia lack convenient access to many services, including health care. The West Virginia Children's Health Project was designed to provide primary pediatric care to underserved children using a fully equipped mobile medical clinic. The clinic visits elementary schools and other host sites throughout Lincoln and Wayne counties on a regular weekly schedule. Most of the children served are Medicaid eligible.

The clinic is staffed by a pediatrician, a pediatric resident, a pediatric nurse practitioner or a licensed practical nurse, and a driver/registrar. Health care services provided on the mobile clinic are predominantly preventive in nature, including routine checkups and screenings for medical, dental, and mental health problems. Health education is provided to parents and elementary school teachers, both individually and in groups. The health care team also treats acute health problems, such as earaches and sore throats. The project has identified many children lagging in their physical and/or mental development, and children with problems beyond the scope of the clinic are referred to specialists at Marshall University's Department of Pediatrics, a consortium member.

As of May 1997, the mobile clinic had provided medical services to 1,792 children in 3,157 encounters. Were it not for this outreach project, most of these children would not have received adequate care. Also during this period, the project provided medical and dental screenings to 3,146 individuals, and 5,884 individuals attended its health education programs. Finally, the mobile clinic served as a training ground for 16 pediatric residents.

The West Virginia Children's Health Project had existed before receiving the outreach grant, but on a smaller scale. Through the outreach grant, and the support of the consortium, the project has been able to expand its services, particularly its outreach component, and enjoy a much improved financial stability. The Harts Health Center, a community health center, leads the project's consortium and provides primary care services. The Marshall University Department of Pediatrics provides medical direction and pediatricians for the mobile clinic. The Cabwaylingo Presbyterian Chapel, a small rural church, serves as a weekly host site and promotes the project in the community. Completing the consortium are the four elementary schools, one

PROJECT **77**

WEST VIRGINIA CHILDREN'S HEALTH PROJECT

middle school, and one high school that serve as weekly host sites.

Telephone communication between clinic staff and physicians, pharmacists, or staff persons at the health center has been essential for clinic operations. At each site, project staff run an extension cord and a phone line from the van to a utility pole that houses an electrical outlet and a phone jack. The consortium is collaborating on a telecommunications project with several community health centers and two area hospitals, which should improve the communications system considerably.

One of the key factors in this project's success has been the support of its consortium members, particularly school and church personnel. Referred to by the project coordinator as "ambassadors to the community," these principals, teachers, parent volunteers, and ministers have helped to demystify the van and win the trust of rural residents. These individuals have also served as conduits through which the project frequently hears the community's perceptions of its services.

Flexibility also contributed to the project's success. For example, throughout the grant period, the project closed less productive sites and opened others. This strategy allowed for the recent initiation of services in the project's first high school. The success of another site helped spawn the creation of a comprehensive primary health care center in an adjacent community. "The success we realized happened to a great extent because we discarded our mistakes and changed to respond to realities," writes the project coordinator.

Given its patient base, it is not expected that the project will be self-supportive after the outreach grant expires. However, the consortium hopes to continue the mobile medical clinics, and even expand into new sites, through support from corporate and private funding sources.

PROJECT **78**

OCCUPATIONAL HEALTH AND SAFETY MIGRANT AND INDUSTRY MOBILE HEALTH UNIT

Sacred Heart-Saint Mary's Hospital, Inc., Rhinelander, Wisconsin

Contact:
Cary Bever,
Executive Director

Sacred Heart-Saint Mary's Hospital, Inc.
1044 Kabel Avenue
Rhinelander, WI 54501
(715) 369-6633

Three hospitals and a migrant health center in central Wisconsin have implemented a mobile health clinic to provide occupational health and safety services to industrial and migrant workers throughout a twenty-county region. The 25-foot mobile health clinic, staffed by bilingual nurses aides, is equipped with electricity, a propane-powered generator, and batteries so that it can accommodate sites ranging from industrial settings to the middle of a cucumber field.

Services provided on board vary depending on the setting. Clients from business and industry primarily use hearing tests, pulmonary function screens, drug and alcohol tests, laboratory tests, and work-related physical exams. Services are designed to assist employers in identifying health risks, complying with OSHA regulations, and maintaining a drug-free workplace. As of June 1997, the project had established ongoing relationships with more than 1,000 companies and had performed more than 86,000 procedures. Clients are predominantly white males between the ages of 18 and 55.

Services provided in the migrant camps include physical examinations, hearing tests, pulmonary function screens, laboratory tests, vaccinations, Pap smears, and pelvic examinations. The majority of clients are women, children, and adolescents. As of May 1997, the project had provided services to 1,604 patients at 14 migrant camps and performed 6,939 procedures. Clients are all non-English speaking Hispanics.

Leading the project's consortium is Sacred Heart-Saint Mary's Hospitals, Inc. Its partners are Saint Michael's Hospital, and La Clinica, a migrant health center. The hospitals bring to the project many years' experience in occupational health, and La Clinica contributes its experience in reaching the migrant population and gaining their trust. "Due to the vastly different cultures, missions, and management structures of the organizations involved in this project, it would have been very difficult, if not impossible, to produce this kind of positive impact without the consortium arrangement," writes the project director.

Far and away the most significant challenge to the project involves the long-term treatment of chronic health conditions among the migrant population. Due to the transient nature of this group, it is not possible to manage many of their health concerns to conclusion. The most controversial example is that of tuberculosis testing and follow-up. Infected individuals

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PROJECT **78**

OCCUPATIONAL HEALTH AND SAFETY MIGRANT AND INDUSTRY MOBILE HEALTH UNIT

started on a tuberculosis treatment regimen cannot be followed up after they return home, so treatment is rarely completed. This course of incomplete treatment frequently produces drug-resistant strains, further complicating future treatment. "As this debate continues on the national level," writes the project director, "many in the medical community contend that any attempt to diagnose, let alone treat, tuberculosis among this group is a poor use of resources."

This issue and its implications for the outreach project remain unresolved. "The principle lesson we have learned," writes the project director, "is that we cannot always expect or demand the same level of result in each treatment environment. Especially in the underserved, difficult-to-reach populations, we have to recognize the limitations in our abilities to positively affect the health condition of all people equally."

Much of the work started under this grant will continue through the development of two joint ventures involving all consortium members. La Clinica and Saint Michael's Hospital have developed a joint venture designed to strengthen La Clinica's presence in the area as well as provide for the development of a new migrant health clinic. It is not clear whether the mobile clinic will be used in these efforts. In addition, Sacred Heart-Saint Mary's Hospital, Inc. and Saint Michael's Hospital have developed a subsidiary corporation dedicated to delivering occupational medicine services to business and industry. While neither project is expected to be financially viable on its own, the sponsoring hospitals will provide financial support to ensure their continued service within the region.

PROJECT **79**

"HAND IT ON DOWN" HEALTHY LIFESTYLES PREVENTION PROGRAM

Wind River Health Promotion Program, St. Stephens, Wyoming

Contact:
Lisa Appelhans,
Executive Director

Wind River Health
Promotion Program
P.O. Box 248
St. Stephens, WY 82524
(307) 856-3405

The "Hand It On Down" Healthy Lifestyles Prevention Program is a culturally specific, health promotion/substance abuse prevention project for individuals living on or near the Wind River Indian Reservation in west central Wyoming. The project's main focus is to implement educational, cultural, and recreational activities to encourage healthy lifestyle choices as alternatives to alcohol and substance abuse. About 30,000 members of the Eastern Shoshone and Northern Arapaho Tribes live on the reservation; the unemployment rate is 71%. Due to the high prevalence of risk factors associated with substance abuse on the reservation, all youth are encouraged to participate in project activities.

One of the cornerstones of this project is the incorporation of tribal culture and traditions. During its first six months, the project recruited and trained six elders to serve as positive role models for youth and provide instruction in traditional crafts, storytelling, Native American drumming, and singing. These mentors also teach students about traditional values and beliefs.

The project has also implemented multisession, culturally appropriate drug prevention programs in the schools, housing projects, and the larger community. As of May 1997, 1,700 sessions of these programs had been given, with more than 27,000 in attendance (individuals are counted each time they attend). Other prevention activities include recreational activities as an alternative to substance abuse (3,559 participants), annual conferences related to substance abuse issues (320 in attendance), youth leadership training sessions (90 participants), sobriety/wellness camps, and a culturally specific parent education program called "Native Ways."

The project has also developed an intensive multimedia campaign to generate community support, increase awareness and knowledge about substance abuse problems, and encourage participation in program activities.

Finally, the project has worked to strengthen and formalize the referral process among consortium members so that participants in need of substance abuse treatment programs can receive the assistance they need. Activities in this area include the development of accessible, coordinated options for substance abuse treatment, relapse prevention and follow-up, and outreach efforts to families affected by substance abuse problems. As of May 1997, consortium members had referred 200 individuals to treatment programs.

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PROJECT 79

"HAND IT ON DOWN" HEALTHY LIFESTYLES PREVENTION PROGRAM

Leading the project's consortium is the Wind River Health Promotion Program, a community-based organization. Other consortium members include the Indian Health Service, the Shoshone and Arapaho Tribal Health Services, two tribal HUD programs, several tribal youth organizations, and eight public schools located on or near the reservation.

A small number of project activities will continue after the grant period through support from consortium members. These activities include youth conferences and cultural activities incorporated into after school and summer school programs. As of May 1997, the project had submitted several grant applications but had not received additional funding. It had also submitted a proposal to the Joint Business Council of the Shoshone and Arapaho Tribes requesting funds for salaries and a portion of the program.

The Ministry of Health for the Republic of Palau implemented the Palau Lead Poisoning Prevention Program in 1994 to determine if lead poisoning was a threat to this Pacific Island nation. The Republic of Palau is an archipelago of 200 islands, nine permanently inhabited, located in the far southwestern corner of the Pacific Ocean, about 500 miles west of the Philippines and 500 miles north of New Guinea. The republic was the last United Nations trustee administered by the United States. Since gaining independence as a Freely Associated State in October 1994, it maintains close economic, social, and political ties with the United States.

The majority of the nation's 17,000 residents are impoverished and medically underserved. Most travel is by boat because the only paved roads are located on the 7.1-square-mile island of Koror, the republic's administrative and economic capital, and neighboring Airai.

Although the republic's piped water systems had been tested for lead in 1993 and found to have levels sufficiently below the United States Environmental Protection Agency's action level of 15 micrograms per liter (ug/l), Palau's Ministry of Health was concerned that the islands' rainwater catchment systems, the main source of drinking water for many island residents, had never been tested. Contamination of these systems could result from drainage off rooftops painted with lead-based paints, or from components such as faucets, pipes, and soldered joints. A second area of concern was ceramicware imported from foreign countries that may have been improperly finished with lead-based glazes.

Based on these concerns, the Ministry of Health formed a consortium with the Palau Environmental Quality Protection Board and the Ministry of Education. The three-agency consortium arrangement gave the project maximum exposure in the community, and each agency contributed valuable skills and expertise that the other two could not provide. Five staff members from these three agencies were assigned full-time to this project.

One component of the project was a public awareness campaign to inform the public of the risk of lead contaminants in the environment. Outreach activities included town hall meetings in each of Palau's 16 states, a school-based lead poisoning awareness program, and the distribution of informational brochures. All outreach activities were conducted in the Palauan

PALAU LEAD POISONING PREVENTION PROGRAM

Ministry of Health,
Koror, Republic of Palau

Contacts:
Masao M. Ueda,
Minister of Health

Marjan Najafi,
Project Coordinator

Office of Federal and
International Programs
Ministry of Health
P.O. Box 6027
Koror, Republic of
Palau PW 96940
011-680-488-2813 or 488-2552
011-680-488-1211 fax
8091 PNCCPW Telex

PROJECT **80**

PALAU LEAD POISONING PREVENTION PROGRAM

language with respect for Palauan culture and traditions.

The second project component was the measurement of blood lead levels from a representative sample of children and pregnant women. Ministry of Health project staff provided case management for children identified with high blood lead levels. They also determined the risk of lead ingestion from glazed ceramicware and pottery in private homes, restaurants, and stores. The Palau Environmental Quality Protection Board surveyed stores to determine the presence of lead-containing products, and determined the lead concentrations of water from rural rainwater catchment tanks and public water systems.

The study did find sources of lead in this island nation. Based on blood lead screenings of 885 Palauan children ages 0-6, the adjusted prevalence rate of childhood lead poisoning in Palau was projected to be 2.8%. This translates to nearly 75 children who have blood lead greater than 10 micrograms per deciliter (_g/dl). To date, the screenings have identified a total of 56 lead poisoning cases in children. Case management for each case has involved environmental site investigations to identify the source of lead and limit or prevent exposure. The main sources of exposure have been found to be lead-based paints and the practice of melting lead in the house, usually from dead car and boat batteries, to make fishing weights. None of the children with lead poisoning had blood lead levels high enough to warrant chelation treatment.

Of the 334 water samples taken from rural catchment tanks and public water systems, 2% were determined to be above the action limit of 15 ug/l. Of particular concern was a type of catchment tank used at all the Head Start centers throughout Palau. Levels as high as 120 ug/l were recorded for water drawn from this type of tank. As a result, the Palau Community Action Agency, which manages the 20 Head Start centers throughout Palau, replaced these tanks with a safer variety, and implemented an ongoing blood lead screening program for all Head Start children. Finally, ceramicware containing lead was identified in a small number of stores and one restaurant. None of the 171 pregnant women screened tested positive for blood lead contamination.

Project staff hope that the study's findings, and the regulations proposed by Palau to ban or control the import of lead-containing products, will be useful to other communities in the U.S.-associated Pacific Islands. At the present time, none of the health

departments in these jurisdictions has established lead poisoning prevention programs. While lead poisoning may not be a significant problem for these nations currently, improved public awareness and lead-control policies may prevent future cases of lead poisoning in young children.

PALAU LEAD POISONING PREVENTION PROGRAM

Consortium agencies will continue to support many of the grant activities after funding expires. These activities include blood lead screening for all children age 2-5 participating in the Head Start program; case management of existing and newly identified lead poisoned children; testing of lead levels in water and ceramicware; a program to collect lead acid batteries in the community; and lead poisoning education in elementary and high schools.

Many of the residents of Puerto Rico's southeastern mountains live in isolation and poverty. The nearest providers of primary care services are located in the small urban centers of Arroyo and Patillas, at least 30 to 90 minutes away. The Rural Outreach ProjEct (ROPE) was designed to link area residents with these distant health care centers. It has also established five rural facilities in these outlying areas to provide access to education, health maintenance, and disease prevention services within the local community. Space for these rural facilities is provided by the city governments of Arroyo and Patillas, both of which are consortium members.

All of the individuals enrolled in the ROPE program are medically indigent and of Hispanic origin. Median annual income is less than $2,500. A majority of program participants are elderly and chronically ill, most commonly with diabetes, respiratory diseases, and hypertension. Some are physically disabled or mentally ill.

Rural patients first receive a medical evaluation from the project's family practitioner and are referred to the Family Health Centers of Arroyo and Patillas (both consortium members) for primary, secondary, and emergency care as needed. Follow-up appointments, however, are conducted at the local ROPE facility. Here, the health care team ascertains compliance with treatments and provides ongoing health education and counseling services. Project staff also conduct in-home visits when the patient is physically disabled or too frail to visit a ROPE facility.

Other project services include transportation to medical appointments for low-income and physically disabled patients, and dispensing of medications to medically indigent patients without insurance.

The project's comprehensive health care team includes a family practitioner, a psychologist, a project coordinator with a Masters degree in social work, three registered nurses, three licensed practical nurses, a health educator, a secretary, and a driver.

As of May 1997, the project had enrolled and followed 645 individuals. About half of these have received health maintenance services for chronic illness, and another 180 have received psychosocial/social work counseling. As a consequence of these services, patient compliance with treatment has improved, and inappropriate emergency room visits have declined by 25% for patients enrolled in the program. An additional 6,000 rural

PUERTO RICO

RURAL OUTREACH PROJECT (ROPE) FROM THE SOUTHEAST RURAL HEALTH OUTREACH CONSORTIUM

Dr. Julio Palmieri Ferri
Family Health Center,
Arroyo, Puerto Rico

Contacts:
Fabri Montanez,
Executive Director

Julio Gonzalez-Monclova,
Model Consultant

Dr. Julio Palmieri Ferri
Family Health Center
Morse Street, Corner
of Valentina Street
Arroyo, Puerto Rico
Mailing Address:
Box 477
Arroyo, Puerto Rico 00714
011-787-790-3821

PROJECT 81

RURAL OUTREACH PROJECT (ROPE) FROM THE SOUTHEAST RURAL HEALTH OUTREACH CONSORTIUM

residents have received health education services through outreach activities, namely workshops and health fairs.

Perhaps the most important lesson learned by this project is that "each rural area has its own personality and way of doing things," writes the project director. "Local politics and public attitudes must be considered when serving a rural community." In addition, she writes, "health education and promotion strategies must take into account differences in age, sex, sexual preferences, religion, educational levels, and other cultural factors. Mixing populations must be done carefully by experienced professionals or peers, or else it could backfire."

The Dr. Julio Palmieri Ferri Family Health Center in Arroyo serves as the project's lead agency. The other consortium members are the Patillas Family Health Center in Patillas, and the city governments of Arroyo and Patillas.

The health care system in Puerto Rico has undergone significant reform during the last few years. These changes will affect the ROPE project as its federal outreach grant expires. Under the new system, the Family Health Centers in the area will form an Integrated Service Network, similar to an HMO, that will reimburse ROPE's educational and preventive health care services. The project is also seeking other federal grants to expand services to rural individuals at risk for domestic violence, drug abuse, HIV/AIDS, and other sexually transmitted diseases.

Services	*Project Number*
Adult Day Health Care	45
Advocacy	8, 18, 32, 39, 67
Blood Drive	24
Car Seat Rental Programs	43
Case Management	2, 4, 6, 9, 13, 18, 26, 30, 35, 36, 37, 46, 47, 49, 67, 69, 75, 80
Chemical Analysis of Soil and Water	44
Child Abuse Prevention/Intervention	3, 54
Conferences/Workshops	47, 79
Crisis Intervention and Prevention	6, 27, 61
Day Camps	29,44, 56, 63, 79
Dental Care	11, 21, 32, 49, 76
Dentures	72
Diabetes Management	5, 8, 13, 21, 25, 52
Directory of Services/Resource Guide	7, 14, 16, 43, 46, 68, 72
Domestic Violence, Support Services for victims of	4, 6
Drug and Alcohol Testing	56, 78
Eldercamp	7
Emergency Medical Services (EMS) Enhancements	29, 48
Emergency Triage	26
Employment and Training Services	6, 18, 47
Exercise Facility	19, 41
Eyeglasses	72
Family Planning	3, 4, 16, 35, 36, 37, 46, 55, 69
First Aid	25, 50
Head Start Screenings	53, 56
Health Assessments/Risk Assessments	14, 34, 41, 43, 46, 49, 50, 52, 62, 66
Health Checks (formerly EPSDT)	2, 12, 57
Health Fairs	3, 14, 16, 24, 28, 43, 44, 45, 46, 60, 65, 71, 74, 81
HIV/AIDS Testing/Case Management	4, 31, 49
Home Health Care Visits	3, 5, 6, 8, 17, 23, 25, 30, 31, 35, 49, 52, 54, 55, 56, 59, 81
Home Psychiatric Nursing	15
Home Safety	10, 49

Hospice Care	38
Hospital Alliances/Affiliations	59, 76
Housekeeping	16
Immunizations	1, 2, 3, 4, 6, 11, 16, 21, 23, 25, 43, 45, 50, 53, 56, 57, 58, 59, 60, 62, 66, 76, 78
Injury Prevention	10, 29
Intergenerational Programs	7, 8, 10, 17, 39, 79
Laboratory Tests	1, 4, 5, 13, 24, 25, 43, 50, 57, 59, 60, 66, 78
Lead Testing and Screening	59, 60, 80
Legal Counseling for the Elderly	8
Mammography	6, 11, 43, 66, 76
Meals to Homebound Elderly	8, 16, 56
Medicaid Eligibility Counseling	3, 4, 6, 9, 13, 35, 72
Medications, dispensing	12, 24, 25, 49, 81
Medications, financial assistance	13, 30, 32, 46, 72
Medications, monitoring	61
Mental Health Services	1, 3, 4, 5, 6, 8, 12, 13, 14, 15, 16, 17, 18, 21, 25, 26, 28, 30, 36, 42, 50, 51, 56, 60, 61, 65, 74, 75, 76, 81
Mobile Health Clinic	1, 3, 5, 11, 26, 43, 53, 76, 77, 78
Newsletters	76
Occupational Therapy/Occupational Health and Safety	42, 56, 78
"One Stop Shopping" (combined service clinics)	16, 31, 49, 75
Outcomes Research/Evaluation	60, 75
Peer Companion Program (for the elderly)	8
Physical Therapy	56
Prenatal/Perinatal Care	2, 4, 21, 23, 31, 35, 37, 46, 52, 54, 69, 76
Preventive Health Care	1, 3, 4, 12, 21, 24, 25, 26, 29, 34, 37, 39, 40, 41, 43, 44, 45, 46, 47, 50, 52, 53, 56, 58, 59, 63, 66, 76, 77, 78, 81
Primary Care	1, 4, 6, 8, 21, 24, 26, 30, 32, 33, 34, 35, 43, 46, 50, 52, 57, 59, 60, 62, 66, 71, 77, 78

Public Health	3, 4, 5, 16, 31, 35, 50, 53, 59, 60, 69, 76
Publications	7, 8, 22, 34, 66, 68, 76
Radiology Services	13, 43, 59, 60
Referrals	1, 2, 3, 4, 5, 8, 9, 10, 12, 13, 14, 15, 16, 18, 22, 23, 24, 25, 30, 32, 34, 35, 36, 37, 39, 43, 47, 50, 52, 53, 56 61, 65, 68, 72, 76, 77, 79, 81
Rehabilitation Therapy	22, 26
Respite Care	7
School-based Case Management	46
School-based Health Care	1, 12, 14, 25, 37, 41, 50, 52, 60, 77
School-based Health Education	1, 10, 12, 14, 25, 34, 41, 45, 50, 55, 65, 74, 77, 79, 80
School-based Mental Health Counseling	1, 14, 17, 25, 28, 50, 65
School/Sports Physicals	45, 52, 76, 77
Screenings (general)	1, 3, 5, 7, 11, 14, 16, 21, 24, 25, 26, 29, 37, 40, 41, 43, 44, 46, 49, 50, 54, 56 58, 65, 66, 76, 77, 78
Screenings (specific)	
Alzheimer's Disease	58
Breast Cancer	6, 11, 21, 76
Cervical Cancer	21, 76, 78
Cholesterol	5, 11, 14, 41, 44, 45, 53, 58
Dental	1, 11, 50, 66, 77
Developmental Delays/Learning Problems	25, 57, 77
Diabetes	5, 8, 11, 21, 25, 53
Lead Poisoning	80
Hearing	1, 4, 11, 12, 14, 25, 40, 41, 50, 57, 58, 66, 78
Home Safety	10
Hypertension	5, 14, 40, 41, 53, 58
Mental Health	1, 3, 5, 8, 15, 18, 56, 65, 77
Prostate Cancer	44, 58

Pulmonary Function	78
Skin Cancer	44
Scoliosis	1, 16, 25, 41, 50
Stroke Risk Factors	22
Substance Abuse	47, 49, 61
Vision	1, 11, 12, 25, 41, 50, 54, 66
Social Services Eligibility Counseling	2, 4, 6, 8, 13, 30, 35, 53, 56
For TennCare beneficiaries	67
Speech Therapy	56
Substance Abuse Treatment	4, 13, 18, 21, 28, 47, 49, 61, 79
Outreach and Casefinding	47, 49, 61, 79
Counseling	4, 18, 28, 47, 49, 60, 61, 79
Support Groups	2, 8, 17, 21, 22, 27, 28, 33,
Anger Management	74
Bereavement	8, 38
Cancer	33
Caregivers of the Elderly	22
Substance Abuse Recovery	18, 47, 74, 79
Teen Parenting	2, 55, 74
Teleconferencing	6, 26, 33, 42, 71, 75
Telemedicine	6, 22, 26, 33, 37, 42, 71, 75
Telepsychiatry	26, 33, 42, 75
Teleradiology	33
Telephone Assessment	32
Telephone Emotional Support Line	7, 8, 27, 39, 54
Telephone Health Information	34, 68, 76
Telephone Psychiatric Consultations	15, 26
Telephone Referrals	32, 34, 39, 68, 76
Translation Services	13, 47, 69
Transportation to Medical and Social Services	5, 7, 9, 12, 18, 23, 29, 30, 36, 45, 47, 49, 52, 54, 56, 58, 59, 72, 73, 76, 81
Tuberculosis Testing/Management	25, 49, 53, 78
Vision Services	8
Well Child Exams	2, 4, 6, 23, 52, 54, 57, 59, 76, 77

Well Water Testing	80
WIC Nutritional Services/Certification	13, 16, 21, 23, 31, 35, 53, 59, 60, 76
Women's Health	16, 21, 31, 52, 53, 78
Population Group	*Project Number*
Adolescents	1, 6, 12, 14, 17, 21, 28, 36, 37, 39, 44, 45, 46, 50, 55, 56, 60, 65, 66, 74, 78, 79
Adolescents, delinquent	17
Chemically Dependent	4, 13, 18, 21, 28, 30, 31, 47, 49, 60, 74, 75, 79
Children	2, 3, 4, 6, 10, 11, 12, 13, 16, 17, 21, 23, 25, 29, 34, 37, 41, 44, 46, 53, 54, 56, 57, 59, 60, 63, 65, 66, 72, 77, 78, 79, 80
Criminal Justice System (those involved in)	18
Deaf and Hearing Impaired	75
Developmentally Disabled	3, 26
Diabetic Patients	5, 8, 13, 16, 21, 25, 34, 52, 81
Disabled	7, 15, 16, 73, 81
Elderly	3, 7, 8, 10, 13, 15, 16, 17, 22, 40, 41, 44, 45, 49, 53, 56, 58, 59, 60, 61, 66, 73, 76, 81
Caregivers of the Elderly	7, 22
HIV/AIDS Patients	4, 31, 49
Homebound	15, 16, 49, 56, 73
Homeless	13, 30
Hypertension Patients	5, 11, 13, 22, 34, 52, 58, 81
Hyperlipidemia/Heart Disease Patients	5, 58
Infants	2, 3, 16, 17, 21, 23, 35, 54, 57, 80
Mentally Ill	3, 5, 6, 8, 13, 15, 16, 17, 18, 19, 26, 27, 28, 30, 33, 42, 51, 56, 60, 74, 75, 81
Migrant and Seasonal Farm Workers	21, 47, 49, 68, 69, 76, 78

Minorities	
African American	12, 30, 36, 47, 49, 72
Amish	29
Asian and Pacific Islanders	13, 80
Caribbean Islanders	47
Filipino	13
Hispanics	3, 5, 9, 13, 21, 30, 47, 49, 68, 69, 71, 72, 76, 78, 81
Native Americans	3, 44, 51, 56, 73, 79
Native Hawaiians	13
Postpartum Women	2, 6, 17, 21, 23, 35, 54, 55, 66
Pregnant Women	2, 6, 16, 17, 21, 23, 31, 35, 36, 37, 52, 54, 55, 69, 80
Single Mothers	2, 23, 39, 66
Terminally Ill	38
Caregivers of the Terminally Ill	38

Continuing Education for Health Professionals	*Project Number*
Dietitians	64
Emergency Medical Services Personnel— Pre-hospital	
Emergency Medical Technicians (EMTs)	6, 20, 29, 33, 42, 60, 64, 70, 71
Paramedic Training for EMTs	20
Firefighters	71
First Responders	6, 71
Medical Dispatchers	6
Paramedics	71
Emergency Room Personnel	
Physicians	20
Registered Nurses	20
Home Healthcare Providers	64
Hospice Caregivers	38
Medical Students	26, 38, 70
Mental Health Professionals	42
Nonphysician Primary Care Providers	22, 26, 51, 60, 64, 70

(Nurse Midwives, Nurse Practitioners, Physician Assistants, Community Health Workers)	
Nurse Midwives	69, 70
Nursing Students	1, 60
Paraprofessional Outreach Workers	6, 10, 23, 39, 68
Physical Therapists	64
Physicians	20, 22, 26, 29, 33, 34, 42, 64, 70
Psychiatrists	42
Psychologists	42
Registered Nurses	20, 22, 26, 33, 42, 64, 70
Residents	26, 77
Social Workers	42, 64
Substance Abuse Treatment Program Staff	47
Other	
Administrators	26, 64
Foster Parents	70
Teachers	42
Topic	
Cultural Diversity/Sensitivity	47
Geriatrics	64
Injury Prevention	10
Stroke Treatment/Prevention	22
Satellite-based Continuing Medical Education	64, 70
Telecommunications network (interactive)	6, 20, 26, 33, 42, 64
Health Promotion/Education	*Project Number*
Health Promotion/Disease Prevention (general)	1, 2, 3, 7, 8, 12, 14, 16, 25, 26, 29, 30, 31, 33, 35, 37, 39, 40, 41, 43, 44, 45, 49, 50, 52, 53, 56, 57, 65, 66, 71, 72, 77, 78, 81
Health Promotion/Disease Prevention (specific)	
Accessing Health Care Services	13, 32, 39, 65, 72

Accessing Social Services	13, 30, 35, 39, 56, 69, 72
Agricultural Safety	29
Alcohol Abuse	47, 79
Alzheimer's Disease	45
Assistive Technology Devices	
Bereavement	38
Breast Cancer Prevention	11, 21, 44
Breastfeeding	35
Breast Self Examination	11
Cancer Prevention	16, 21, 44, 45
Cardiovascular Health	16, 29, 44, 45
Careers in Health Professions	60
Childbirth	33, 35, 69
Cholesterol Reduction	5, 29, 41, 44, 58
Conflict Resolution	25
CPR	29, 34, 43, 45
Depression	5, 45
Diabetes	5, 13, 16, 21, 34, 81
Domestic Violence/Dating Violence	46, 74
Elderly Health Issues	7, 8
Family Planning	3, 4, 35
Farm Safety	29, 43, 44, 63
Farmworker Health	68
First Aid	43
Fitness	8, 16, 19, 34, 41, 43, 45
Heart Disease	16, 29, 44
HIV/AIDS	49
Hospice	38
Hypertension	5, 13, 40, 41, 58, 81
Injury Prevention	10, 29, 41, 63
Lead Poisoning Prevention	80
Living Wills	45
Medication Compliance	13
Mental Health	14, 27, 45, 51, 65, 74

Native American Culture/Traditions	79
Nutrition	1, 5, 13, 15, 25, 29, 31, 34, 35, 36, 41, 43, 44, 45, 46, 50, 53, 76
Occupational Health and Safety	60
Parenting	2, 4, 6, 23, 36, 41, 46, 50, 54, 55, 57, 60, 66, 74, 79
Pregnancy Prevention	36, 37, 55
Prenatal Health	31, 35, 69
Respiratory Illness	81
Self Esteem	25, 36, 46, 56
Sexual Harassment	46
Sexually Transmitted Diseases	50
Smoking Cessation	16, 34, 41, 44
Sports Injuries	45
Stress/Anger Management	16, 41, 45, 74
Stroke Prevention	22
Substance Abuse	28, 47, 49, 50, 79
Suicide Prevention	25
Teen Issues	14, 36, 37, 45, 46, 55, 56, 65, 74, 79
TennCare Benefits	67
Tractor Certification	29
Tuberculosis Prevention/Management	49, 78
Weight Management	19, 34, 41
Health Information Resource Center	41
Patient Education Videos	34, 44
Peer Counseling	27, 74

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Child and Family Outreach Project, Williamsburg, Kentucky 23
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Community-based Approach to Strengthening Rural Health Services, Milbank, South Dakota 62
Community Health Outreach, Talbott, Tennessee 65
Community Oriented Mapping and Addressing/ Enhanced Telecommunication(COMET), Marshall, North Carolina 48
Connections for Care, Salisbury, Maryland 30
The Divide Wellness Center, Placerville, California 4
Elderly Rural Health Outreach, Putnam, Connecticut 8
Farmworker Alcohol and Substance Abuse Project, Ithaca, New York 47
Finney County Primary Care Project, Garden City, Kansas 21
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